Medicare

Part A Intermediary Manual

ORIGINAL

Part 4
Audit Procedures

COMPLETED

U.S. Department of
Health and Human Services
Health Care Financing Administration
HCFA—Pub.13-4
Reprint Date (1-85) Thru Rev. 9

164

This manual has been reprinted to incorporate all revision transmittals issued through the reprint date. It should be noted that the material contained in this reprinted manual is exactly the same as that contained in manuals being maintained by the incorporation of revision transmittals.

Copies of the reprinted manuals should not be ordered to replace older editions.

I

CHECK SHEET OF INTERMEDIARY MANUAL REVISION TRANSMITTALS - PART 4

This check sheet should be placed at the front of the Part 4 section of the manual to provide a record of manual revisions.

HE 22.7/6-4:

01. 9/33
02. 11/78
03. 11/38
04. 1/13
05. 6/13
06. ✓
07. 10/5
08. 10/2
09. 1/7/85
10.
11.
12.
13.
14.
15.
16.
17.
18.
19.
20.
21.
22.
23.
24.
25.
26.
27.
28.
29.
30.
31.
32.
33.
34.
35.
36.
37.
38.
39.
40.
41.
42.
43.
44.
45.
46.
47.
48.
49.
50.
51.
52.
53.
54.
55.
56.
57.
58.
59.
60.
61.
62.
63.
64.
65.
66.
67.
68.
69.
70.
71.
72.
73.
74.
75.
76.
77.
78.
79.
80.
81.
82.
83.
84.
85.
86.
87.
88.
89.
90.
91.
92.
93.
94.
95.
96.
97.
98.
99.
100.

II

101. ______
102. ______
103. ______
104. ______
105. ______
106. ______
107. ______
108. ______
109. ______
110. ______
111. ______
112. ______
113. ______
114. ______
115. ______
116. ______
117. ______
118. ______
119. ______
120. ______
121. ______
122. ______
123. ______
124. ______
125. ______
126. ______
127. ______
128. ______
129. ______
130. ______
131. ______
132. ______
133. ______
134. ______
135. ______
136. ______
137. ______
138. ______
139. ______
140. ______
141. ______
142. ______
143. ______
144. ______
145. ______
146. ______
147. ______
148. ______
149. ______
150. ______
151. ______
152. ______
153. ______
154. ______
155. ______
156. ______
157. ______
158. ______
159. ______
160. ______
161. ______
162. ______
163. ______
164. ______
165. ______
166. ______
167. ______
168. ______
169. ______
170. ______
171. ______
172. ______
173. ______
174. ______
175. ______
176. ______
177. ______
178. ______
179. ______
180. ______
181. ______
182. ______
183. ______
184. ______
185. ______
186. ______
187. ______
188. ______
189. ______
190. ______
191. ______
192. ______
193. ______
194. ______
195. ______
196. ______
197. ______
198. ______
199. ______
200. ______

CHAPTER 1

MANAGEMENT AND ADMINISTRATIVE FUNCTION

Reporting of Provider Audit Activity

	Section	Page
Quarterly Provider Audit Activity Report (HCFA-1822)..	4009	4-21/1
Purpose..	4009.1	4-21/1
Distribution and Due Date..........................	4009.2	4-21/1
Instructions for Completion........................	4009.3	4-21/1
Edit Checklist.....................................	4009.4	4-30/10
Exhibit of HCFA-1822...............................	4009.5	4-31/11
Cost Report Settlement Log (HCFA-1823)...............	4010	4-32/12
Purpose..	4010.1	4-32/12
Distribution and Due Date..........................	4010.2	4-32/12
Instructions for Completing the Cost Report Settlement Log	4010.3	4-32/12
Instructions for Completing the Cost Report Settlement Log for Home Office and Malpractice Insurance Reviews....................	4010.4	4-36/16
Edit Checklist.....................................	4010.5	4-38/18
Exhibit of HCFA-1823...............................	4010.6	4-40/20

Audit Priority Matrix

	Section	Page
Audit Priority Matrix................................	4013	4-51/21
Introduction.......................................	4013.1	4-51/21
General Instructions...............................	4013.2	4-51/21
Application of the Audit Priority Matrix...........	4013.3	4-52/22
Procedure for the Matrix Process...................	4013.4	4-53/23
Level of Audit Effort..............................	4013.5	4-53/23
Exhibit A..	4013.6	4-54/24
Exhibit B..	4013.6	4-55/25

Audits

	Section	Page
General Instructions for Submitting Cost Report Data to HCFA	4020	4-103/26
Submission of Automated Cost Reports	4021	4-104/27
Cost Reports Submitted Via Timesharing Systems	4021.1	4-104/27
Cost Reports Submitted on Magnetic Tape	4021.2	4-104/27
Approval of FI Transmission Process	4021.3	4-107/30

	Section	Page
HCRIS Standard Input Format	4021.4	4-108/31
Identification Data and Data from Sources Other than the Cost Report	4021.4.1	4-108/31
Standard Format for Data From Worksheets	4021.4.2	4-111/34
Labeling Format	4021.4.3	4-113/36
Table 1: Worksheet Indicators	4021.4.4	4-115/38
Submission of Manual Cost Reports	4022	4-120/43
HCRIS Detailed Cost Report Requirements and Edits	4023	4-122/45
HCRIS Detailed Data Requirements	4023.1	4-122/45
Financial Data Requirements	4023.2	4-123/46
Labeling of Cost Centers	4023.3	4-123/46
Edits to be Applied	4023.4	4-123/46
Table 2: Medicare Cost Report Data Specifications	4023.5	4-124/47
Table 3: Values for Special Codes	4023.6	4-179/116
Specific Worksheet Instructions and Examples	4024	4-181/118
General Instructions for Determining Lines and Columns	4024.1	4-181/118
Statistical Data - Part I	4024.2	4-181/118
Statistical Data - Part II	4024.3	4-182/119
Statistical Data - Part III	4024.4	4-182/119
Statistical Data - Part IV	4024.5	4-182/119
Statistical Data - Part V	4024.6	4-182/119
Statistical Data - Part VI	4024.7	4-183/120
Statistical Data - Part VII	4024.8	4-183/120
Worksheet A	4024.9	4-184/121
Worksheet A-1	4024.10	4-184/121
Worksheet A-2	4024.11	4-184/121
Worksheet A-3	4024.12	4-184/121
Worksheet A-4	4024.13	4-184/121
Worksheet A-5	4024.14	4-184/121
Worksheet A-6	4024.15	4-184/121
Worksheet A-7	4024.16	4-184/121
Worksheet A-8	4024.17	4-185/122
Worksheet A-8-1	4024.18	4-185/122
Worksheet A-8-2	4024.19	4-185/122
Worksheet B	4024.20	4-185/122
Worksheet B-1	4024.21	4-185/122
Worksheet C	4024.22	4-185/122
Worksheet D	4024.23	4-185/122
Worksheet D-1	4024.24	4-185/122
Worksheet D-2	4024.25	4-186/123
Worksheet D-3	4024.26	4-186/123
Worksheet D-8	4024.27	4-186/123
Worksheet E	4024.28	4-186/123
Worksheet E-1	4024.29	4-186/123
Worksheet E-5	4024.30	4-186/123

	Section	Page
Worksheet G	4024.31	4-187/124
Worksheet G-1	4024.32	4-187/124
Worksheet G-2	4024.33	4-187/124
Worksheet G-3	4024.34	4-187/124
Supplemental Worksheet D-4	4024.35	4-187/124
Supplemental Worksheet D-5	4024.36	4-187/124
Supplemental Worksheet D-6	4024.37	4-187/124
Supplemental Worksheet D-7	4024.38	4-187/124
Supplemental Worksheet E-3	4024.39	4-187/124
Supplemental Worksheet E-4	4024.40	4-187/124
Supplemental Worksheet F	4024.41	4-187/124
Supplemental Worksheet A-8-3	4024.42	4-188/125
Supplemental Worksheet D-9	4024.43	4-188/125
Supplemental Worksheet H Series	4024.44	4-188/125
Supplemental Worksheet I Series	4024.45	4-188/125

Reporting of Provider Audit Activity

4009. QUARTERLY PROVIDER AUDIT ACTIVITY REPORT (FORM HCFA-1822)

4009.1 Purpose.-The purpose of the Form HCFA-1822 is to provide HCFA with the basic data needed to measure the intermediaries' timeliness of processing providers' reimbursable cost statements and to evaluate the current status of audit activity. This information enables HCFA to develop and to revise standards in the area of timeliness standards for provider cost report settlement and provides the means of measuring the intermediaries' performances with respect to those standards.

Multi-regional intermediaries prepare a separate Form HCFA-1822 for each field location which maintains an audit and reimbursement function.

4009.2 Distribution and Due Date.--Complete the HCFA-1822 on a quarterly basis. It is due on the 20th of the month following the end of the reporting quarter; e.g., the October-December 1984 report is due on January 20, 1985. Complete and forward two copies of the report directly to:

Health Care Financing Administration
Division of Reports and Analysis, BQC
Room 239 East High Rise
6325 Security Boulevard
Baltimore, MD 21207.

Indicate Form HCFA-1822 on the bottom right corner of the envelope. Send one copy of the report to the appropriate regional office.

NOTE: Complete the HCFA-1822 in such fashion (preferably typed) that the data are easily readable. If one or more of the copies are photocopies, the copies must be legible, complete, and contain information on only one side.

4009.3 Instructions for Completion.—Accumulate and prepare on a quarterly basis all data to be reported. The preparation of this report should not require an exhaustive review of source data, since the data should be organized so that the information needed is readily available at the end of the reporting quarter.

Complete a separate HCFA-1822 for each type of provider served and check the appropriate block for the type of provider. Complete a summary form. Include on the summary page only provider data, i.e., hospitals, HHAs, SNFs and PTs—not home offices, LPICs, etc. In addition, do not include RHC data on the summary page. Intermediaries which have been selected to process independent Rural Health Clinic (RHC) claims are required to submit a separate Form HCFA-1822 on their RHC audit activity.

In the event a multiple facility exists, e.g., Hospital-SNF, Hospital-HHA, Short Term Hospital-Long Term Hospital, report a cost report for each provider which has been assigned its own provider number. For example, if a hospital has a SNF facility attached and both entities have individual provider numbers, report two cost reports; i.e., enter one report into the count reported on Form HCFA-1822 with hospital checked as type of provider and enter one report into the count reported on Form HCFA-1822 with SNF checked as type of provider.

Otherwise, each provider type should be self-explanatory with the exception of "other." Some examples of the type of entities to report in this category include: Malpractice Limited Purpose (Captive) Insurance Companies, Self Insurance Pooled Trusts, Renal Dialysis Free-Standing Facilities, Histocompatability Laboratories, and Organ Procurement Agencies.

NOTE: An intermediary designated as the Home Office (HO) intermediary prepares the HCFA-1822 for all HOs within its jurisdiction. This instruction also applies to Malpractice Insurance Companies and Self-Insurance Pooled Trusts.

Enter the intermediary name and number in the space provided. In addition, indicate the reporting quarter e.g., October-December 1984, January-March 1985. Do not use numbers to indicate the quarter.

A. Provider's Fiscal Year Ending Date.--The form HCFA-1822 is designed to accommodate a break-down of audit activities for provider fiscal year ending dates, grouped by calendar quarters for the current Federal government fiscal year and the two preceding fiscal years and an annual total for the third preceding fiscal year. This data is entered in column A-lines 1 through 13. Enter in section "O" the total number of unsettled cost reports for all provider fiscal year ends prior to the third preceding fiscal year (e.g., FY 1981 and earlier for reports filed for FY 1985). In addition, a single line (14)—current fiscal year—is provided for intermediary activity in the current fiscal year involving all cost reports; i.e., cost reports with fiscal years ending (FYE) in the current fiscal year or prior. Make entries in total on the current fiscal year line and in the appropriate calendar quarter for the provider's FYE.

For example, for reporting quarters in FY 1985 the form accommodates a total for FY 1982, FYEs quarterly break-out for FYEs in FYs 1983, 1984, and 1985, and a summary line for FY 1985 activity. In this manner, the form can be used on an ongoing basis. Explain in the remarks section of the report adjustments made to correct errors or record changes from prior reports.

2

B. Number of Cost Reports FYE In Period--To Be Filed.--Enter in this column the number of hospitals (HHAs, SNFs, PTs, RHCs, Chain Home Offices, or other entities according to page) certified for Medicare that have FYEs occurring in periods shown under column A and from which a cost report has been or will be submitted.

The total figure should also include those providers having either minor or no Medicare business. If a change is approved in a provider's cost reporting period so that two cost reports fall within a particular fiscal year, include both reports in this column.

Example

During the Federal Government's fiscal year ending September 30, 1984, hospitals A, B, and C have fiscal years ending as follows:

Hospital A - December 31, 1983
Hospital B - March 31, 1984
Hospital C - September 30, 1984

The numbers of cost reports to be filed for these three hospitals is recorded in the Provider Audit Activity Reports for all reporting quarters of FY 1984 as shown below.

A. Provider's Fiscal Year Ending Date	Number of Cost Reports FYE in Period	
	B. To Be filed	C. Currently Due
FY 83 4th Qtr.		
FY 84 1st Qtr.	1	
FY 84 2nd Qtr.	1	
FY 84 3rd Qtr.	0	
FY 84 4th Qtr.	1	
Current FY		

3

C. Number of Cost Reports FYE In Period--Currently Due.--Enter in this column (on a cumulative basis) the number of cost reports from hospitals (HHAs, SNFs, PTs, RHCs, Chain Home Offices, or other entities according to page) recorded in column B that are now currently due and should be in the possession of the intermediary. (See example below.) A report is considered "currently due" as follows:

1. Provider Continues to Participate in Program.—

a. Cost reports are "currently due" the last day of the third month following the close of the period covered by the report or 30 days after that date if an extension has been granted.

b. Where a hospital or hospital-based SNF or hospital-based HHA submits a certified cost report that has been audited by the independent auditors of the hospital, the cost reports are "currently due" on the last day of the fourth month following the close of the period covered by the report or 30 days after that date if an extension has been granted.

2. Provider Agreement to Participate in Program Terminates (Voluntarily or Involuntarily) or Provider Experiences Change of Ownership.--Cost reports are "currently due" 45 days following the effective date of the termination of the provider agreement or change of ownership.

3. Cost reports are "currently due" if received before the date that they are due.

When a provider fails to submit a cost report and the case is subsequently turned over to the appropriate regional office, the report is not entered as "currently due." However, the report is entered in column "B" (To Be Filed). When the report(s) are secured from providers by the regional office and referred to the intermediary or if the report is filed directly with the intermediary, make an entry in column C and explain in the remarks section.

EXAMPLE

Refer to the same three hospitals from the example in section 4009.3 B. Hospital A's fiscal year ended December 31, 1983, and a certified cost report was to be filed no later than April 30, 1984 (4 months). It was received by the intermediary on April 20, 1984. Hospital B's fiscal year ended March 31, 1984, and a cost report was to be filed no later than June 30, 1984 (3 months). The report was not filed until September 1, 1984. No extensions for late filing had been granted and the matter had not been referred to the regional office. The cost report for Hospital C will not be due until December 31. Therefore, make no entries in the cost report due column for Hospital C in the current fiscal year.

4

Beginning with the April-June 1984 Provider Audit Activity Report enter counts for hospitals A and B in column B adjacent to fiscal year ending column FY 84 1st quarter and FY 84 2nd quarter, respectively, as shown below:

A. Provider's Fiscal Year Ending Date	B. To Be Filed	C. Currently Due	D. Received
FY 83 4th Qtr.			
FY 84 1st Qtr.	1	1	1
FY 84 2nd Qtr.	1	1	0
FY 84 3rd Qtr.	0	0	0
FY 84 4th Qtr.	1		
Current FY		2	1

Number of Cost Reports FYE in Period

Beginning with the October-December 1984 Provider Audit Activity Report enter count for hospital C in column B adjacent to fiscal year ending column FY 84 4th quarter as shown below:

5

A. Provider's Fiscal Year Ending Date	Number of Cost Reports FYE in Period		
	B. To Be Filed	C. Currently Due	D. Received
FY 83 4th Qtr.			
FY 84 1st Qtr.	1	1	1
FY 84 2nd Qtr.	1	1	1
FY 84 3rd Qtr.	0	0	0
FY 84 4th Qtr.	1	1	0
FY 85 1st Qtr.	1*		
FY 85 2nd Qtr.	1*		
FY 85 3rd Qtr.	0		
FY 85 4th Qtr.	1*		
Current FY		1	0

* Represents cost reports for hospitals A, B, and C for following year.

D. Number of Cost Reports FYE in Period--Received.--Enter for each FYE period in column A the number of cost reports received which are complete enough to permit a desk review. A complete cost report contains all required forms and is submitted with the proper provider certification. All pages must be complete or marked as not applicable. A listing submitted with the cost report, indicating pages contained in the report and those pages not offered because of non-applicability, is an appropriate substitute.

Only providers having minor or no Medicare business are permitted to file less than full cost reports.

E. Desk Reviews Completed For No Audit.--Enter for each FYE period in column A the number of cost reports on which a desk review was completed and a decision made not to conduct 16 hours or more of work at the provider site. The desk review is considered completed when the technical and professional analysis of the cost report has been accomplished--including the determination of audit scope.

A desk review cannot be considered complete without the physical receipt of a cost report. Cost reports for providers having either minor or no Medicare business during the fiscal year are included in this column if the required cost report data has been received, i.e., page 1 of the cost report.

F. Desk Review Completed-To Be Audited.--Enter for each FYE period in column A the number of cost reports on which a desk review was completed and a decision made to conduct 16 hours or more of work at the provider's site. The desk review is considered completed when the technical and professional analysis of the cost report has been accomplished—including the determination of audit scope.

NOTE: For lines E and F: It may be determined during desk review that a cost report will require 16 hours or more work at the provider site, and be reported as such (in column F) on the HCFA-1822. If, however, the time actually required falls short of the 16-hour criterion, the next and all subsequent HCFA-1822s filed, as appropriate, must be corrected to reflect the cost report in column E and not in column F. (Settlement of the cost report would be reported in column I, "Settlement Without Audit.")

Conversely, if it becomes necessary to spend 16 hours or more at the provider site for a cost report previously determined to require less than 16 hours of onsite work, it is necessary to correct subsequent HCFA-1822s. In general, explain any such corrections in section P—Remarks.

G. Desk Review Completed--Total.--Enter the total number of desk reviews completed during the reporting quarter (the sum of columns E and F).

H. Field Audit Completed.--Show for each FYE period in column A the number of cost reports for which the audit capability (intermediary staff or subcontractor) has completed work of 16 hours or more at the provider site. Completion of the field work occurs when the audit capability concludes the onsite examination of the provider's records, holds an exit conference and leaves the facility to prepare the audit report—even though subsequent visits to the facility may be necessary to clarify points raised during the review and preparation of the audit report.

I. Settlements-Without Audit.--Enter for each FYE period in column A the number of cost reports settled by the intermediary without the benefit of 16 hours or more work at the provider site. A cost report is considered settled with the issuance of a Notice of Program Reimbursement (NPR).

J. Settlements-With Audit.--Show for each FYE period in column A the number of cost reports on which the NPR was issued after 16 hours or more work at the provider site.

7

Audits of chain organization home offices present an exception to the above instructions for items I and J. No NPR is issued for the home office since it is not a provider with an agreement with the Secretary and individual NPRs are issued for each provider. For home office only, the definitive action is the issuance of the audit report to the servicing intermediary by the intermediary responsible for the home office audit.

If all activities leading to the settlement of chain provider cost report have been completed except that the servicing intermediary has not received notification of home office costs that will be allocated to the provider, do not report this cost report as settled but do report this cost report under suspensions (column L). Also report the total number of such cases included under column L in the remarks section broken down by fiscal year ending date.

K. Settlements-Total.--Enter the sum of columns I and J.

L. Suspensions.--Enter for each FYE period in column A the number of cost reports on which activity is in suspension as of the end of the reporting quarter. Suspensions to be reported are those formally directed by HCFA (either Central or Regional Offices), HHS, GAO, etc. Primary causes of suspensions are fraud, abuse, overpayments, bankruptcy, etc.

In each suspension, it is necessary to determine the affected cost reporting periods as it may involve more than one cost report. It is not necessary to reflect in column L suspensions initiated and subsequently lifted within the same reporting quarter. Therefore, the report reflects only outstanding suspensions as of the end of the reporting quarter.

M. Reopenings Initiated.--Enter for each FYE period in column A the number of reopenings initiated. For purposes of this report, the term "reopenings initiated" means the issuance of a notice of reopening to the provider or in the case of a provider's filing of an amended report the acceptance of that amended report. Reopenings may be initiated by the intermediary or at the direction of HCFA.

NOTE: Intermediaries are to report only reopenings initiated October 1, 1980 and later. If the intermediary initiates on or after October 1, 1980 a reopening of a cost report with a FYE prior to the fiscal year shown in column A-line 1 (of the HCFA-1822), the number of reopenings initiated and completed is reflected in section P—Remarks. For example, the HCFA-1822 for the October-December 1984 quarter could show in section P--Remarks, 1 reopening initiated and 1 reopening completed based on the following:

Cost Report - FYE - 9/30/79
Reopening Initiated - 10/15/84
Reopening Completed - 12/12/84

N. Reopenings Completed.--Enter for each FYE period in column A the number of reopenings completed. A completed reopening is any adjustment, made to a provider's cost report after the NPR had been issued, related to action taken by the intermediary, an intermediary's hearing officer, the PRRB, HCFA, or the Secretary, to reexamine or question the correctness of a determination or decision otherwise final, and resulting in a revised NPR, a Notice of Correction (see Intermediary Manual, Part 3, section 2631), or a letter stating that (1) no change in reimbursement has resulted from the reopening, or (2) the amended report has been rejected.

O. Number of Unsettled Cost Reports for Prior Periods.--Enter the number of unsettled cost reports for fiscal years prior to that covered by column A-line 1 of the report (i.e., those not covered by the data submitted in the body of the report). It is not necessary to break out the reports by fiscal year.

P. Remarks.--Use this space to offer an explanation of any of the data reported in the body of the report. For example, when delinquent cost reports are filed, enter an explanation in this section (see C--Number of Cost Reports Currently Due).

Q. Report Prepared By.--The report is signed and dated by the person who actually prepared the form. Be sure that the individual's name and telephone number are typed on the form.

4009.4 Edit Checklist

Follow the checklist to assure accuracy and consistency of Form HCFA-1822 data:

1. Indicate the provider type in the space provided in the top center.
2. A valid five digit intermediary number should appear in the top right center.
3. The appropriate quarter and year for the reporting period should appear in the top right of the form.

For lines 1-13:

4. Column C should never exceed column B.
5. Column D should never exceed column C.
6. Columns E through N individually should never exceed column D.
7. Column N should never exceed column M.

For all lines:

8. Column E plus column F should equal column G.
9. Column I plus column J should equal column K.

10

EXHIBIT

QUARTERLY PROVIDER AUDIT ACTIVITY REPORT

TYPE OF PROVIDER
☐ HOSPITAL
☐ HHA
☐ SNF
☐ PT
☐ RHC
☐ HD
☐ OTHER (SPECIFY) ________
☐ SUMMARY

NAME OF INTERMEDIARY

INTERMEDIARY NUMBER

REPORTING QUARTER

A. PROVIDERS FISCAL YEAR ENDING DATE	NUMBER OF COST REPORTS FYE IN PERIOD			DESK REVIEWS COMPLETED			H. FIELD AUDIT COMPLETED	SETTLEMENTS			L. SUSPENSIONS	REOPENINGS	
	B. TO BE FILED	C. CURRENTLY DUE	D. RECEIVED	E. FOR NO AUDIT	F. TO BE AUDITED	G. TOTAL		I. WITHOUT AUDIT	J. WITH AUDIT	K. TOTAL		M. INITIATED	N. COMPLETED
1. FY													
2. FY____ 1st Quarter													
3. FY____ 2nd Quarter													
4. FY____ 3rd Quarter													
5. FY____ 4th Quarter													
6. FY____ 1st Quarter													
7. FY____ 2nd Quarter													
8. FY____ 3rd Quarter													
9. FY____ 4th Quarter													
10. FY____ 1st Quarter													
11. FY____ 2nd Quarter													
12. FY____ 3rd Quarter													
13. FY____ 4th Quarter													
14. Current FY													

O. NUMBER OF UNSETTLED COST REPORTS FOR PRIOR PERIODS

P. REMARKS

Q. REPORT PREPARED BY

FORM HCFA-1872 (11-80) PREVIOUS EDITIONS ARE OBSOLETE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

4010. COST REPORT SETTLEMENT LOG (HCFA-1823)

4010.1 Purpose

The purpose of the Cost Report Settlement Log (Form HCFA-1823) is to gather sufficient data to enable HCFA to evaluate the cost report settlement activity on a national, regional, and individual contractor basis. The data is used to monitor the intermediaries' provider reimbursement and cost report settlement activities on a current basis and to assess their effectiveness. It is further anticipated that the data will be used both internally and externally by HCFA to determine the funds required to achieve and operate at a desired level of performance and select providers for CREP reviews.

4010.2 Distribution and Due Date

Complete the Form HCFA-1823 on a monthly basis. It is due 20 days following the end of the month; e.g., the December report is due on January 20. Maintain a log in such a manner that entries are made as final action is taken (i.e., chronologically). Complete and forward two copies of the report to:

Health Care Financing Administration
Division of Reports and Analysis, BQC
Room 239 East High Rise
6325 Security Boulevard
Baltimore, MD 21207.

Indicate Form HCFA-1823 on the bottom right of the envelope. Also, send one copy of the report to the appropriate regional office.

NOTE: Complete the HCFA-1823 in such fashion (preferably typed) that the data are easily readable. If one or more of the copies are photocopies, the copies should be legible, complete, and copied on only one side of the paper.

4010.3 Instructions for Completing the Cost Report Settlement Log (Also see Section 4010.4 for Instructions for Completing the Log for Home Office and Malpractice Reviews)

Report all cost reports settled during the month on the log; if a settlement is inadvertently overlooked report it the following month or as soon as possible thereafter. Segregate data by type of provider and activity (e.g., all hospital settlements together, SNF settlements together, hospital reopenings together).

NOTE: In general, report corrections of previously reported data in the current month's report by creating a section labelled "notice of corrections" at the bottom of the HCFA-1823. Reference the data previously incorrectly reported to the particular reporting month to be corrected in the right-most column and show the exact duplicate (of the previously reported) data in brackets. Underneath the line to be corrected show the correct data (with all appropriate columns completed).

A. Headings

1. Intermediary—Complete the intermediary's name in the same manner as on the HCFA-1822. See section 4009.

2. Month/Year—Enter the month and year for which settlements are being reported.

B. Columns.—Complete columns 1 through 19 for all final settlements (where an NPR has not previously been sent to the provider). Complete columns 1 through 21 for reopened cost reports. A reopened cost report is defined as any adjustment made to a provider's cost report after the NPR had been issued, related to action taken by the intermediary, an intermediary's hearing officer, the PRRB, HCFA, or the Secretary, to reexamine or question the correctness of a determination or decision otherwise final. Enter the reopening on the HCFA-1823 only after issuance of a revised NPR, a Notice of Correction (see Intermediary Manual, Part 3, section 2631), or a letter stating that (1) no change in reimbursement has resulted from the reopening, or (2) the amended report has been rejected.

1. Provider Number.—Enter the 6-number provider identifier for the cost report settled. If the report is for a multiple provider facility; e.g., hospital/SNF, hospital/RHC, report all provider numbers using a separate line for each and fill in all appropriate columns for each line. The provider numbers indicate the type of provider for which cost reports have been settled.

2. Provider Name.—Enter the provider's name. In the case of a multiple provider facility, ditto marks may be used on subsequent lines instead of repeating the name.

3. P or N.—Indicate with a letter designation if the provider is proprietary (whether profit or nonprofit) or nonproprietary. Add a "C" to the designation if the provider is part of a chain, whether home office costs are included in the cost report or not.

P - Proprietary
N - Nonproprietary
PC - Proprietary chain provider
NC - Nonproprietary chain provider

4. Reporting Period - FYE.—Enter the last day (month, day, and year) of the reporting period if the cost report is for a full year.

NOTE: For cost reports covering less than 12 months or cost reports covering more than 12 months, enter both the beginning and ending dates.

5. Date Cost Report Received.—Enter the date (month, day, year) the provider's cost report was received. For reopened cost reports, enter on the second line the date the reopening was initiated, i.e., date amended cost report, appeal decision, or RO instruction was received.

6. Date of NPR (Notice of Program Reimbursement).—Enter the date (month, day, year) of the NPR or equivalent (Notice of Correction or final letter in the case of reopened reports).

7. Number of Beds.—Show the number of beds the provider has shown on the cost report at the beginning of the reporting period. Show total beds --not just certified beds. Multiple provider facilities should show the number of beds related to the type of provider; e.g., hospital - 350 beds; SNF - 150 beds; total beds in facility - 500 beds. Use a zero in this column where bed size is not appropriate; e.g., HHAs, RHCs.

8. Medicare Reimbursement Claimed by Provider.—Enter the amount of reimbursable Medicare costs (Part A and Part B) as claimed by the provider on the cost report as filed. For hospitals, SNFs and freestanding SNFs, obtain the data from one of the following sources, according to which type of cost report form was used:

a. HCFA-2551—Schedule 1, Worksheet E, Part III, Line 16.
b. HCFA-2552R—Worksheet E, Part III, Line 17.
c. HCFA-2552-84—Worksheet E, Part III, Line 69 minus Lines 58 and 60. Column 3, 5, 7 and 9, as applicable, net of deductible (if known) times 80 percent.
d. HCFA-2552-83 Worksheet E, Part 3, Line 72 minus 58, net of deductible (if known) times 80 percent.

Obtain the same data for HHAs from HCFA-1728A Worksheet D, Part 2, Line 13. Include reimbursement for such costs as renal dialysis, recovery of lower of costs or charges, bad debts, etc., but exclude PSRO costs. Also exclude those unallowable or questionable costs claimed by the provider to establish appeal rights as identified in the provider's cost report (see HIM-15-2, section 115). Enter the amount for these appealable costs next to column 21 on the right hand side of the HCFA-1823.

NOTE: The data entered in column 8 comes from the original cost report submitted by the provider in order to account for the adjustments to reimbursements (columns 9 and 10) when column 8 is compared to column 11 (Reimbursement per NPR).

9. and 10. Adjustments to Reimbursement as a Result of Settlement:

a. Without Field Audit.—Enter the net result of adjustments to Medicare reimbursable cost as filed where there was less than 16 hours work at the provider site. Exclude those unallowable or questionable costs claimed by the provider to establish appeal rights. The net result of adjustments may be a positive or negative amount. Identify a negative amount by the use of a minus sign (-). If the net adjustment is zero, indicate 0 in this column.

b. After Field Audit.—Enter the net result of adjustments to Medicare reimbursable cost as filed where there was 16 hours or more work at the provider site. Exclude those unallowable or questionable costs claimed by the provider to establish appeal rights. The net result of adjustments may be a positive or negative amount. Identify a negative amount by the use of a minus sign (-). Test the amounts entered in column 9 and 10 by determining the difference between column 8 (Medicare Reimbursement Claimed by Provider) and column 11 (Reimbursement per NPR).

11. Reimbursement per NPR.—The entry in this column reflects the total Medicare reimbursement (excluding PSRO) to the provider for the period shown on the NPR or the Notice of Correction, if a reopened report. See definitions for column (8) above. Obtain the data from the cost report as finally settled.

12. Interim Payments per NPR.—Enter in the right hand side of this column the type of interim payment during the provider's fiscal year. P for PIP non-PPS; C for percent of charges; D for per diem; G for PPS non-PIP; and I for PIP PPS. If the provider received more than one type of interim payment, use the code representing the larger payment(s). Use only one code. Enter in the left hand side of this column the amount of interim payments advanced to the provider during the cost report period. Interim payments are made as bills are processed and should not reflect any tentative or final settlements. For hospitals, SNF and freestanding SNF cost reports, obtain data for column 12 from the following sources:

a. HCFA-2551—Worksheet E, Part 3, Line 17.
b. HCFA-2552—Worksheet E, Part III, Line 18.
c. HCFA-2552-84—Worksheet E, Part III, Line 70.
d. HCFA-2552-83—Worksheet E, Part III, Line 73.

The same data for HHAs are found on HCFA-1728—Worksheet D, Part II, Line 15.

13. and 14. Hours Expended to Settle:

a. No Field Audit.—Enter the direct hours expended to settle the cost report where there was less than 16 hours work at the provider site.

b. Field Audit.—Enter the direct hours expended to settle the cost report where there was 16 hours or more work at the provider site.

Direct hours are those where an individual (professional, supervisor, or clerical) was working on a specific provider cost report (include desk review, audit and settlement effort). Exclude time spent by typists and/or the secretarial staff. Include hours spent in travel status in columns 15 and 16 only (see specific instructions for these two columns). For reopenings, report only hours spent on reopened cost report (see definition under B). The direct hours will not reconcile with productive hours as reported on other reports because general supervision and other general activities are not included in direct hours reported here.

In the event that a subcontractor has performed all or part of the work on the cost report, this field must include a reasonable estimate of the hours spent by the subcontractor.

15. and 16. Travel:

a. Hours.—Enter the direct hours, for which the individual was paid, spent in travel status to settle (include desk review, audit and settlment effort) the cost report. Do not include any hours spent in travel status where the individual was outside his work hours and did not receive compensation. All noncompensated travel hours may be reported as a footnote.

b. Cost.—Enter the travel expenses required to settle the cost report. Travel expenses are transportation, meals, lodging, etc., but exclude personal service costs. For reopenings, report only cost incurred on the reopened cost report. The maintenance, insurance, depreciation costs, etc., of a leased and/or company owned car used for company travel purposes, may be considered as part of the costs.

17. and 18. Utilization - Days/Visits:

a. Medicare - Report Medicare hospital/SNF days or HHA/PT/RHC visits.

b. Total - Report total hospital/SNF days or HHA/PT/RHC visits.

19. FYE of Previous Cost Report Field Audited.—Enter the ending date (month, day, and year) of the last cost report settled for this provider for which the intermediary did 16 hours or more work at the provider site.

Note: Reopened Cost Reports.—When reporting data for amended and reopened cost reports, please use the following format. Show two lines of data. In columns (1) through (19) of the first line enter in brackets ( ) the data from the original NPR or last notice of correction, whichever applies. These data should duplicate exactly the data submitted when the cost report was originally settled or last corrected. On the second line show all new data in columns (1) through (21) as though it were a new NPR. In columns 13 and 14 of the second line report only the hours spent on the reopened cost report. In columns 15 and 16 of the second line report only costs incurred on the reopened cost report.

20. Date and reason for reopening.—Indicate the date the cost report was reopened and the reason, as follows:

A-Provider request to amend cost report

F-Fraud and abuse investigation

H-Home office adjustment necessary

I-Required by intermediary appeal decision

P-Required by PRRB decision

Q-Required by HCFA regional or central office as a result of the Quality Assurance Program

O-Other - Any reopening not covered above

21. Date of Original NPR.—For reopened cost reports, enter the date of the NPR as a result of the final settlement.

4010.4 Instructions for Completing the Cost Report Settlement Log for Home Office and Malpractice Insurance Reviews

Intermediaries are designated by HCFA to review data on these entities. When the assignment is made, the intermediary should maintain records to complete the log in the following manner.

A. Columns

1. Provider Number.—Instead of a provider number, indicate "H" for home office statement or "M" for malpractice insurance arrangement review.

2. Provider Name.—Indicate name of chain if home office or name of malpractice insurance arrangement.

3. P or N.—Indicate for home office reviews whether the entity is P - proprietary (whether profit or nonprofit) or N - nonproprietary. This column is not applicable to malpractice reviews (leave blank).

4. Reporting Period - FYE.—Indicate fiscal year end of home office or the reporting period for the malpractice insurance arrangement period being reviewed.

5. Date Cost Report Received.—Indicate date home office statement or malpractice insurance data received.

6. Date of NPR.—Enter date home office or malpractice review report of findings was released to servicing intermediaries.

7. Number of Beds.—Not applicable to home office or malpractice insurance arrangements - leave blank.

8. Medicare Reimbursement Claimed by Provider.—Enter the total home office or malpractice insurance costs being reviewed. See Intermediary Manual, Part 3, Section 2170 for home office costs to be reviewed and Provider Reimbursement Manual (HIM 15-1) Section 2163 for allowable malpractice insurance costs.

9. and 10. Adjustments to Reimbursement as a Result of Settlement.—Indicate in the approprate column the net adjustments made as a result of the review.

11. Reimbursement per NPR.—Indicate the costs allowed prior to allocation to chain providers as a result of the review.

12. Interim Payments per NPR.—Not applicable to home office or malpractice insurance arrangements - leave blank.

13. and 14. Hours Expended to Settle.—Indicate the direct hours expended to perform the review and issue report of findings. See Section 4010.3 B.13 and 14.

15. and 16. Travel.—Indicate the direct hours and cost expended for travel to perform the review and issue report of findings. See Section 4010.3 B.15 and 16.

17. and 18. Utilization - Days/Visits.—Not applicable to home office and malpractice insurance arrangements - leave blank.

19. FYE of Previous Cost Report Field Audited.—Enter the ending date of the last reporting period which was field audited.

20. and 21. Reopened Cost Reports.—Complete as indicated in Section 4010.3 B.20 and 21.

4010.5 Edit Checklist

Follow the checklist to assure accuracy and consistency of HCFA-1823 data:

1. A valid five digit intermediary number should appear in the top right of the form HCFA-1823.
2. The appropriate month and year for the report should appear in the top right portion of the form HCFA-1823.
3. Column 1 should contain a valid six digit provider number (Exception: home office and malpractice reviews where the letters "H" and "M" are considered valid provider numbers).
4. Column 2 should contain the name of the provider. If the provider is a multi-provider complex (e.g., a hospital-SNF complex), the provider's name should be repeated for all portions of the complex. Each portion should have its own unique provider number.
5. Column 3 should be filled in the "P", "NP", "PC", or "NC." (Exception: If the provider number is "M", column 3 should be blank.)
6. Column 4 should contain a valid date no later than the reporting month and year.
7. The date in column 5 should be later than the date shown in column 4 and not later than the reporting month and year.
8. The date in column 6 should be later than the date shown in column 5 and not later than the reporting month and year.
9. Column 7 should contain an entry if the provider is a hospital or SNF.
10. Column 8 should contain a positive number.
11. If column 9 is filled in, then column 13 should be filled in and columns 10 and 14 should not be filled in.
12. If column 10 is filled in, then column 14 should be filled in and columns 9 and 13 should not be filled in.
13. Columns 9 and 10 may have a positive or a negative entry.
14. Column 11 should equal the sum of columns 8 and 9 or columns 8 and 10.

15. In addition to the dollar amount shown in the left hand side of column 12, an alpha character (P, C, D, G, or I) must also be present in the right hand side of this column.

16. If there is an entry in column 13, there should be no entry in column 14.

17. If there is an entry in column 14, there should be no entry in column 13.

18. Column 17 should never be more than column 18. However, data could be equal.

19. The date in column 19 must be earlier than date shown in column 4.

20. In addition to the date in column 20, if any, there must be an alpha entry as well (an A, F, H, I, P, Q, and O only).

21. The date in column 21, if any, must be earlier than the date entered in column 20.

COST REPORT SETTLEMENT LOG

INTERMEDIARY NAME

INTERMEDIARY NUMBER

MONTH/YEAR

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)		(13)	(14)	(15)	(16)	(17)	(18)	(19)	(20)	(21)
PROVIDER NUMBER	PROVIDER NAME REPEAT IF MULTIPLE FACILITY	[illegible]	REPORTING PERIOD FYE	DATE COST REPORT RECEIVED	DATE OF NPR	[illegible]	MEDICARE REIMBURSEMENT CLAIMED BY PROVIDER	ADJUSTMENTS TO REIMBURSEMENT AS A RESULT OF SETTLEMENT WITHOUT FIELD AUDIT	AFTER FIELD AUDIT	REIMBURSEMENT PER NPR	INTERIM PAYMENTS PER NPR	AUDITS	HOURS REQ'D TO SETTLE NO FIELD AUDIT	FIELD AUDIT	TRAVEL [illegible]	COST (OUT OF POCKET)	UTILIZATION DAYS/VISITS MEDICARE	TOTAL	FYE OF PREVIOUS COST REPORT FIELD AUDITED	REOPENED COST REPORTS DATE AND REASON FOR REOPENING	DATE OF ORIGINAL NPR

AUDITS

FORM HCFA-1823 (1-81)

* U.S. GOVERNMENT PRINTING OFFICE: 1984-421-858:1435

20

BEST COPY AVAILABLE

4013 AUDIT PRIORITY MATRIX

4013.1 Introduction.—The Audit Priority Matrix is a planning tool for you to use in budgeting audit activity in accordance with HCFA's general instructions and budgeted resources. The matrix allows you to prioritize audits in accordance with the audit budget dollars available. The HCFA RO will meet with you to discuss, and reach agreement on, the projected number of audits and level of resources for each category, in accordance with the budget dollars available. This ensures that there is a general agreement between you and the RO on the budgeted audit resources available and the general audit plan or priority of their allocation.

Continue to base actual audit decisions on your preview process, desk review and professional surveys of providers' filed cost reports. The Audit Priority Matrix provides the framework and general guidelines within which to operate.

4013.2 General Instructions.—The information to show in the matrix is the total projected audit hours for each category, as well as the total number of providers. The actual audit hours spent on any one provider's cost report depends upon the problems revealed by its review, and the audit priority to which it was assigned at budget time. Since the matrix is based on estimates, the priority may change as circumstances do. For example, changes of ownership or terminating providers would rarely be identifed at budget time. Thus, be flexible in adapting the matrix plan to circumstances.

For each level of audit priority, allocate budgeted audit hours under the appropriate provider classifications, as well as the total units to review. The total audit budget is reflected on the matrix, expressed as audit hours. In an attachment to the matrix, equate these audit hours to the monetary budget. For example, 1000 hours on the matrix under hospitals, prospective payment providers, might be expressed on the attachment as representing $15,000 of audit budget funds. The amounts shown on this attachment must agree with the hours and units, shown in Part 3 of the HCFA-Form 1525A.

If it becomes necessary to substantially change the levels of audit priorities, prepare a revised matrix agreed to by you and the RO. (It is not our intention to require such changes on a regular basis.) Examples of this might be a HCFA decision to extend your audit procedures because of subsequent interpretation of legislative changes, or reopenings necessitated by chain home office reviews. Changes of this nature necessitate a revision of resource allocation.

Comment quarterly to the RO on any significant variances (annualized) between the matrix and expected performance for each priority level, in total, for all providers. The tolerance to use is the same as for other quarterly reporting (HCFA-1525A) -5% annualized.

It is our intention that the ROs monitor the original matrix on a quarterly basis. This means that the RO reviews the time and units, and notes any substantial fluctuations; however, this review is based upon comparisons to the HCFA-1525A and not from a quarterly matrix. Furthermore, in order to clarify the comparisons to the HCFA-1525A, the matrix figures should agree with the hours and units reflected in Part 3 of the HCFA-1525A, in addition to the travel costs associated with audit in point (b).

21

Because the provider mix in each region is diverse, the priorities may vary for each region. Furthermore, some priorities, such as terminations and changes of ownership may not always warrant an audit. Therefore, use the matrix as a guide rather than as a mandated format. However, apply the levels of audit priority, i.e., the priority groups, consistently.

4013.3 Application of the Audit Priority Matrix

A. General.—The Audit Priority Matrix enables you, in concert with the ROs, to effectively use and allocate your available audit resources. When common audits are performed for other payors such as Medicaid or private business, take this fact into account in establishing priorities.

General application of the matrix process involves two basic procedures. First, assign priority to each provider cost report within the audit universe according to HCFA's general audit objectives and instructions. For this process, a Schedule of Audit Priority Order (see Exhibit A) is provided. Next, in priority order, the audit workload is posted on the Audit Priority Matrix in accordance with the specified Level of Audit Priority.

The matrix process prioritizes audits according to the objectives of the Medicare program. In application, the audits given the first or greatest degree of priority are those identified within Priority Group I on the matrix. (See Exhibit B.) Priority Group I audits represent special situations which, in general, must be performed. Thereafter, all remaining provider cost reports comprising the audit universe are prioritized according to the Schedule of Audit Priority Order.

B. Schedule of Audit Priority Order.—Exhibit A displays the Audit Priority Order which HCFA established for FY 1985 for all provider types and accounting periods. For FY 1985, the numerical designations 1, 2, and 3 represent the minimum audit expectations issued by HCFA in the Medicare Contractors' Budget Guidelines. The remaining designations (4 through 9) represent the assigned priorities for the remaining provider workload as budget resources permit.

C. Audit Priority Matrix.—Exhibit B displays the framework for scheduling the fiscal year's audit plan by provider type and level of audit priority. Different levels of audit priority are presented in Priority Groupings I through IV designed to assist your selection of providers for audit.

1. Priority Group I.—Providers associated with substantial issues, problems, or HCFA directives. Examples of providers in this category are prospective payment hospitals where target rates may need revision based on legislative changes introduced in the Deficit Reduction Act, or audits involving the waiver States.

2. Priority Group II.—Providers identified within the Schedule of Audit Priority Order. Group II provides further guidance in the audit selection process by providing additional audit priority criteria under its heading.

3. Priority Group III.—Providers identified for cyclical audits. This serves to deter providers, not shown in audit priority areas, from including nonallowable costs in their cost reports. Examples of providers in this category include various hospitals, medium utilization HHAs, and some SNFs. (See §4013.5.)

22

4. Priority Group IV.—Providers which are settled without audit (no audit—as defined in program instructions). Examples in this category are hospitals which have not warranted past audit adjustment, low utilization HHAs, OPTs, and SNFs and freestanding renal dialysis facilities.

4013.4 Procedure for the Matrix Process.—Beginning with the universe of provider cost reports subject to audit, to complete the Audit Priority Matrix follow:

A. Identify, where possible, all provider cost reports with Priority Group I concerns and list on the Audit Priority Matrix;

B. Assign the appropriate Priority Order to the remaining audit workload;

C. List all provider cost reports assigned with Priority Orders 1, 2 and 3 in Priority Group II on the matrix assuring that each is in the appropriate column;

D. As available budget resources permit, list all remaining provider cost reports with priority orders 4-9 on the matrix;

E. Complete Budget Calculation, i.e., units, hours, costs; and

F. Compute and insert total hours and the total number of providers for each provider type, and show grand totals for all providers at the bottom.

4013.5 Level of Audit Effort.—Program instructions require that the level of audit effort be determined by the results (problems discovered) of the desk review or professional survey process, taking into account the audit priority, audit cost to audit savings ratio and the level of budget resources available. In almost all situations, the audits will be limited audits.

Cyclical audits include providers not selected in Priority Groups I or II. Select on a random basis of cost reports received as opposed to the length of time since an audit was last performed (e.g., every fifth cost report). Include any problem resolution required by the professional preview or desk review, and any specific audit procedures established in your audit plan.

EXHIBIT A

SCHEDULE OF AUDIT PRIORITY ORDER

FISCAL YEAR 1985

		Pre-Base Year	Base Year	TEFRA Year	PPS Year
Prospective Payment Provider		Priority 4	Audit Completed	Priority 1	Priority 2
Home Offices		Audit Completed	Audit Completed	Priority 1	Priority 2
Non-Prospective Payment Provider		Priority 4	Priority 2	Priority 2	9
HHAs	over $200,000 in HI reimbursement and at least 50% HI utilization	Priority 5	Priority 5	Priority 3	9
	Other	Priority 7	Priority 8	Priority 7	9
SNFs	over $200,000 in HI reimbursement and at least 10% HI utilization	Priority 6	Priority 6	Priority 3	9
	Other	Priority 7	Priority 8	Priority 7	9
Other		Priority 6	Priority 7	Priority 7	9

AUDIT PRIORITY MATRIX

Levels of Audit Priority	HOSPITALS						HHAs Over $200,000 in HI Reimbursement and Over 50% HI Utilization				SNFs Over $200,000 in HI Reimbursement and Over 10% HI Utilization					
	PPS		Non-PPS		Chain Home Office				Other				Other		Other *	
	Hours	Number Providers	Hours	Number Providers	Hours	Number Providers	Hours	Number Providers	Hours	Number Providers	Hours	Number Providers	Hours	Number Providers	Hours	Number Providers
Priority Group I 1. New providers and providers under fraud or abuse investigation. 2. Terminations and changes of ownership (including mergers and acquisitions). 3. Special situation audits (based on new policy, regulations, and/or CO direction).																
Priority Group II 1. Past Poor Performers (criteria based on prior audits, desk reviews, and your knowledge of provider operations). 2. Audits involving high dollar Medicare reimbursement (based on cost and utilization). 3. Chain managed facilities. 4. Chain owned facilities. 5. Desk reviews where problems were noted.																
Priority Group III 1. Cyclical Audits - No known problem.																
Priority Group IV No Audits																
TOTAL																

*Other includes Hospices, freestanding ESRDs, RHCs, OPTs

Grand Total - All Providers
Audit Hours -
No. of Providers -

☆ U. S. GOVERNMENT PRINTING OFFICE: 1984 - 461-292/20039

BEST COPY AVAILABLE

4020. GENERAL INSTRUCTIONS FOR SUBMITTING COST REPORT DATA TO HCFA

The fiscal intermediary (FI) is required to submit all HCFA-2552-81 (11/81) Medicare Cost Reports from hospitals and hospital/health care facility complexes for fiscal years ending on or after January 1, 1982, except as noted below, to HCFA in accordance with the Hospital Cost Report Information System (HCRIS) specifications. For fiscal years ending prior to January 1982 no cost reports are to be submitted for HCRIS.

The successful transmission of cost report data to HCFA will be used to update the HCRIS data base. This data base will be available to all users authorized by HCFA. The FI is responsible for responding to HCFA inquiries regarding cost report status and data edits. Once a cost report has been accepted into HCRIS, the FI will not be required to supply to HCFA any cost report data or to submit to HCFA any hard copies of that cost report except for Section 223 cost limitation purposes and ongoing quality control verification. The Section 223 cost limit data collection effort will operate until HCRIS' ability to meet the 223 cost limit standard has been demonstrated through the validation review as explained in Section 4021.3. Any requests for hard copy cost reports or requests for any data items for special studies or surveys other than for 223 cost limit purposes should be forwarded to: Bureau of Data Management and Strategy, Office of Statistics and Data Management, Attention: HCRIS Coordinator, 1E-9 Oak Meadows, 6325 Security Boulevard, Baltimore, Maryland 21207.

In general, two submissions of the cost report will be expected for each provider from all FIs. The first will be the cost report "as submitted" by the provider after completion of the mathematical accuracy checks and passing of HCRIS edits as defined in Table 2. This submission must be provided to HCFA within 180 days of the provider's fiscal year end. (For closed and/or merged providers, the submission must be provided to HCFA within 180 days of close or merger.) The only exception is when an "as submitted" cost report is received and the mathematical accuracy checks have been performed by the FI (through its automated desk review (ADR)) prior to October 31, 1982. In this instance, the FI is not required to submit the "as submitted" cost report.

The second submission normally will be the cost report after completion of final settlement, with all adjustments included (after Notice of Provider Reimbursement has been issued). This submission must be sent to HCFA within 30 days after issuance of the Notice of Final Settlement. If the final settlement is made with no changes to the "as submitted" cost report (as previously sent to HCFA), use the Notice of Settlement With No Changes Form (Exhibit 2) rather than retransmitting the cost report. Subsequent submissions under HCRIS are required each and every time a settled cost report is reopened and revised subsequent to the submission to HCFA of data from the prior final settlement. These submissions are due within 30 days after the date of each final settlement.

4021. SUBMISSION OF AUTOMATED COST REPORTS

Automated cost reports are those processed by FIs using a HCFA-approved automated cost report submission process (Section 4021.3). All cost reports must be automated except as noted in Section 4022. The cost report data may be submitted via a timesharing system or on magnetic tape. All FIs must complete the Automated Cost Report Transmission Form shown in Exhibit 1. This form must be completed and immediately mailed to the address indicated on the form to notify HCFA of the data transmission. (For tapes, include the transmission form with the tape.) Provider data can be transmitted separately immediately upon successful processing or can be batched during periods where many cost reports are being transmitted at the same time.

If the settled cost report is identical to the "as submitted" cost report previously sent to HCFA, do not retransmit the cost report. However, the Notice of Settlement With No Changes Form (Exhibit 2) must be completed. Note that if any changes are made, the entire cost report must be retransmitted.

A confirmation letter of data receipt will be mailed to the FI after receipt of every transmission. If not received within 10 working days after data submission, contact: the HCRIS Project Coordinator, at Area Code (301) 597-2383.

4021.1 Cost Reports Submitted Via Timesharing Systems.—Data should be written at the appropriate timesharing system to an account that will be provided by HCFA to the FI. Copy data to the account provided as soon as the data is mathematically accurate and passes the HCRIS edits as specified in Table 2 to prevent incurring additional data storage costs. Once the data have been copied to the HCFA account, all storage and transmission costs will be incurred by HCFA. Data submitted via timesharing systems must comply with Items 7 and 8 of Section 4021.2.

4021.2 Cost Reports Submitted on Magnetic Tape.—Cost reports submitted on magnetic tape must meet the following specifications:

1. Tapes must be 9 track;
2. Density must be 1600 or 6250 and must be specified on the transmission form;
3. Parity must be odd;
4. For IBM standard label tapes, the internal volume serial number must be specified on the Automated Cost Report Transmission Form in the Volume Serial Number location (any FI not using IBM tapes must submit unlabeled tapes);
5. No more than four records per block are permitted;
6. The data set(s) must be accompanied by the Automated Cost Report Transmission Form presented in Exhibit 1;
7. No binary or packed fields are permitted;
8. Data must be formatted according to the specifications contained in Section 4021.4; and
9. All tapes must have an external label.

*U.S. GOVERNMENT PRINTING OFFICE: 1983-381-858:114

EXHIBIT 1
AUTOMATED COST REPORT TRANSMISSION FORM

MAIL TO:

Health Care Financing Administration
Bureau of Data Management and Strategy
HCRIS
P.O. Box 17093
Baltimore, Maryland 21203

Date: ______________________

Fiscal Intermediary Name: ______________________________________

Fiscal Intermediary Number (five-digit number): ______________________

	Provider Number(s) Being Transmitted:	Data Set Name: (for tape submission only):	Label No.
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Number of Cost Reports Being Transmitted: ___________________________

Name and Phone of Technical Contact: __________________________________

____

For tape submission:

Volume Serial Number: ________________

Tape Density 1600 _____ 6250 _____

Labeled Tape Yes _____ No _____

Blocksize: ____________

Additional Remarks:

EXHIBIT 2
NOTICE OF SETTLEMENT WITH NO CHANGES

MAIL TO:

Health Care Financing Administration
Bureau of Data Management and Strategy
HCRIS
P.O. Box 17093
Baltimore, Maryland 21203

Date: ______________________

Fiscal Intermediary Name: ____

Fiscal Intermediary Number (five-digit number): ______________________

The following cost reports have been settled with no changes made to the "as submitted" cost report previously submitted to HCRIS: 1/

Provider Number	Provider Fiscal Year End	Cost Report Status 2/	Date "as submitted" to HCRIS

Remarks: ____

Name and Phone of Technical Contact: ______________________

1/ If *any* changes have been made to the cost report data since transmission of the "as submitted" report to HCRIS, the entire cost report must be retransmitted.

2/ Status:
2 = Settled without audit
3 = Settled with audit

Data can be batched so that one tape contains cost report data for many providers; however, data for each provider must be created as a separate data set, each of which must be specified on the Automated Cost Report Transmission Form. Submit tapes by first class mail at least monthly and within the time constraints established when there are data to be transmitted.

4021.3 Approval of FI Transmission Process.—The FI's automated cost report submission process must be reviewed and accepted by HCFA as meeting the HCRIS cost reporting requirements prior to its use. The FI will be required to demonstrate its data transmission capability by using the cost report input data developed by HCFA. This input data can be acquired by writing to:

Health Care Financing Administration, BPP
Division of Institutional Services Reimbursement
Room 1-A-5 East Low Rise Building
6325 Security Boulevard
Baltimore, Maryland 21207

A cover letter will be enclosed with the input data which gives detailed instructions for processing and transmitting the test package. The HCRIS standard format resulting from the test case must be sent via the timesharing service or via tape as described in Section 4021.2. The transmission form must be completed and clearly marked "TEST CASE."

HCFA will notify the FI in writing within twenty workdays after the receipt of the transmission form as to the approval or disapproval of the FI's ability to provide automated transmission of cost report data for HCRIS. In addition, FIs will be required annually, on a sample basis, to submit hard copies of Medicare Cost Reports to ensure that the 223 cost limit standards, and other HCFA quality control standards, are being met. The FI will retain its approval status until notified by the Bureau of Program Policy (BPP) that retesting of the automated transmission is necessary. Reasons for testing may include:

1. Revised Medicare Cost Report (HCFA-2552-81) format;
2. Inability of FIs to transmit HCRIS data acceptably;
3. When hard copy sampling indicates HCRIS quality control standards are not being met.

At this time, a separate transmission test for HCRIS is necessary for each FI involved. This does not preclude the eventual combining of all HCFA-2552-81 (11/81) test packages into one system approval process. When approved, the FI is responsible for ensuring that the cost report data transmission system remains capable of transmitting HCRIS data acceptably.

In addition, each FI must demonstrate the ability to process data in accordance with HCFA specifications prior to October 31, 1982.

NOTE: Approval or disapproval of the HCRIS transmission process does not validate or invalidate the use of an ADR.

4021.4 HCRIS Standard Input Format.—A single standard format is mandated for submission of data regardless of the automated submission process used. This eliminates the need for development of new standardization software each time there is a new ADR approved, each time a vendor revises its existing system software to conform to a revised version of the cost report, and/or each time a vendor enhances its system.

The format specified requires one field per record. For required data not on the HCFA-2552-81 (11/81), the specified data elements and format are provided in Section 4021.4.1. All data specified in Table 2 must be provided in the format specified in Section 4021.4.2. These data will be identified by worksheet location. Labels are required as discussed in Section 4021.4.3.

The submission of automated data must be according to the following specifications:

1. All data for a given cost report submission must be contained in one data set.
2. All records must have a fixed length of 60 characters.
3. The order of records may vary; however, the first record must be the provider number, and the last record must be the record count (as described in Section 4021.4.1).

4021.4.1 Identification Data and Data from Sources Other than the Cost Report.—As stated, the provider number record must be the first record of the data set and the record count must be the last record. The identification items must be reported in the following format:

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Provider Number Record			This must be the first record of the data.
Record Type	1		"1"
Record Number	9-13	Right	"1"
Provider Number	21-26	Right	Six-digit
Intermediary Number Record			
Record Type	1		"1"
Record Number	9-13	Right	"2"
Intermedidary Number	21-25	Right	Five-digit

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Status of Cost Report Record			
Record Type	1		"1"
Record Number	9-13	Right	"3"
Status of Cost Report	21		1 = As submitted after mathematical checks 2 = Settled without audit 3 = Settled with audit 4 = Reopened
Version of Cost Report Record			
Record Type	1		"1"
HCRIS Number	9-13	Right	"4"
Version of Cost Report	21		1 = 11/81
Intermediary Contact Person Record			
Record Type	1		"1"
Record Number	9-13	Right	"5"
Intermediary Contact Person	21-60	Left	
Intermediary Contact Telephone Number Record			
Record Type	1		"1"
Record Number	9-13	Right	"6"
Telephone Number	21-32		999-999-9999
Date of Transmission Record			
Record Type	1		"1"
Record Number	9-13	Right	"7"
Date of Transmission	21-28		MM/DD/YY; Date data are transmitted or written to tape
All Inclusive Rate Method Record			
Record Type	1		"1"
Record Number	9-13	Right	"8"
All Inclusive Rate Method	21-26	Left	A,B,E, or N (for No); this record need not be present if value is No

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Type of Apportionment Record			
Record Type	1		"1"
Record Number	9-13	Right	"9"
Type of Cost Allocation Method Used	21		1 = Step Down 2 = Double Apportionment - Accumulative 3 = Double Apportionment - Nonaccumulative 4 = Matrix or Simultaneous Equation 5 = Other - Specify
New Provider Record			
Record Type	1		"1"
Record Number	9-13	Right	"10"
New Provider to Program?	21	Left	Y = Yes N = No
ADR Vendor Record			
Record Type	1		"1"
Record Number	9-13	Right	"11"
ADR Vendor	21		1 = Coopers & Lybrand 2 = Ernst & Whinney 3 = John F. Forbes & Co. 4 = Laventhol & Horwath 5 = Blue Cross Blue Shield of Greater New York 6 = Peat, Marwick, Mitchell & Co.
Number of Interns and Residents Record			
Record Type	1		"1"
Record Number	9-13	Right	"12"
Number of Interns and Residents	21-26	Right	
Exemption Record			
Record Type	1		"1"
Record Number	9-13	Right	"13"
Type of Exemption	21	Left	1 = SCP 2 = NP

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Record Count Record			Must be last record of the data.
Record Type	1		"1"
Record Number	9-13	Right	"14"
Record Count	21-26	Right	Count of all records included in the data set including the identification records, data records, label records, and statistical records for the provider.

4021.4.2 Standard Format for Data From Worksheets.--Data elements from the HCFA-2552-81 (11/81) worksheets must be in the following format:

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Record Type	1	Left	Value = "3"
Worksheet	2-8	Left	Specified in Section 4021.4.4, Table 1
Line	9-13	Right	As shown on Cost Report. Worksheet line numbers for cost centers can only be resequenced if the provider has received approval to change the sequence of allocation.
Sub-line Number	14-15	Right	Used for continuation of preprinted HCFA line numbers. Blank when only one line is being assigned to the HCFA line number. If more than one line is being assigned to one HCFA line number, Sub-line Number must be used. Sub-line Numbers begin with 1 and are numbered consecutively.

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Column	16-18	Right	As shown on Cost Report. Worksheet column numbers for cost centers can only be resequenced if the provider has received approval to change the sequence of allocation.
Sub-column Number	19-20	Right	Used for continuation of preprinted HCFA column numbers. Blank when only one column is being assigned to the HCFA column number. If more than one column is being assigned to one HCFA column number, Sub-column Number must be used. Sub-column Numbers begin with 1 and are numbered consecutively.
Numeric Data Value	21-36	Right	Leading zeros can be suppressed; leading negative sign must be given when negative or (negative sign must be present even when paren-theses are preprinted on the cost report); decimal point must be embedded in the data when decimal places are necessary; no other symbols can be embedded in the data (e.g., commas, dollar signs).
Non-Numeric Data Value	21-60	Left	For Yes/No answers Value = "Y" or "N" For dates, use MM/DD/YY format.

Data with zero or blank values can be omitted.

For example, a provider has $12,345 of interest expenses which are applicable to funds borrowed for administrative and general purposes.

The reclassification of this amount from interest expense is indicated on Worksheet A-1, line 15, column 5. These data are indicated as follows:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3A100000   15    5            -12345
```

Specific worksheet instructions and examples are provided in Section 4024.

References to Worksheet A lines. Whenever a Line Number from Worksheet A is requested as data (e.g., Worksheet A line numbers are requested on Worksheet A-6, Line 1, Column 3), the Line Number must match the Line Numbers given in the Worksheet A data. When the Worksheet A Line Number has a Worksheet A Sub-line Number, the Worksheet A Line Number is given in the first Sub-column, the Worksheet A Sub-line in the second Sub-column. For example, on Worksheet A-6, Line 1, Column 3, the reclassification is made to the Worksheet A Line Number 20 Sub-line 5. The Worksheet A Line Number 20 is entered as Line 1, Column 3, Sub-column 1. The Worksheet A Sub-line Number 5 is entered as Line 1, Column 3, Sub-column 2. These data are indicated as follows:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3A600000    1    3 1              20
3A600000    1    3 2               5
```

4021.4.3 Labeling Format.—All labels needed to provide complete identification of nonstandard cost centers, statistical bases, etc. (nonstandard meaning any cost center or statistical basis not preprinted on the HCFA-2552-81 (11/81)) must be provided to HCRIS.

Cost Center Labels. Specify labels for all cost centers if any nonstandard cost centers have been used (nonstandard meaning any cost center or statistical basis not preprinted on the HCFA-2552-81 (11/81)). A detailed explanation of labeling of cost centers is provided in Section 4023.3. These labels are used to identify cost centers on Worksheets A, B, B-1, C, D, and D-1. Report cost center labels as follows:

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Record Type	1		Value = "2"
Worksheet	2-8		Value = "A000000"
Worksheet A Line Number	9-13	Right	Must be identical to Worksheet A Line Numbers in worksheet data

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Worksheet A Sub-line Number	14-15	Right	Must be identical to Worksheet A Sub-line Numbers in worksheet data
Label	21-60	Left	If necessary, abbreviate to fit

Statistical Basis Labels. The statistical base for each column in Worksheet B-1 must be specified if any nonstandard base has been used (nonstandard meaning any cost center or statistical basis not preprinted on the HCFA-2552-81 (11/81)). The title of the column need not be specified--these can be determined from the General Service Cost Centers.
The format for the Worksheet B-1 Statistical Bases follows:

DATA ELEMENT	RECORD POSITION	JUSTIFICATION	CHARACTERISTICS
Record Type	1	Left	Value = "2"
Worksheet	2-8	Left	Value = "B100000"
Worksheet B-1 Column Number	16-18	Right	Must match Column Numbers in worksheet data
Worksheet B-1 Sub-column Number	19-20	Right	Must match Sub-column Numbers in worksheet data
Label	21-60	Left	If necessary, abbreviate to fit

Other Labels. Any additional label changes or specifications must be reported whenever the label is not preprinted on the HCFA-2552-81 (11/81) cost report. This includes changes in labels for the following worksheets where applicable:

Statistical Data Page 3, Part II
Statistical Data Page 5, Parts VI and VII
Worksheet A-1
Worksheet A-2
Worksheet A-3
Worksheet A-4
Worksheet A-5
Worksheet A-6

Worksheet A-7
Worksheet A-8
Worksheet D-1, Lines 25 and 26
Worksheet D-2
Worksheet D-3
Worksheet D-6
Worksheet D-7
Worksheet G
Worksheet G-1
Worksheet G-2
Worksheet G-3
Worksheet F

Report line labels as if they were column zero, and column labels as if they were line zero using the worksheet format specified in Section 4021.4.2.

For example, Line 1 of Worksheet A-6 is labeled "To Reclassify CSS to Med Supplies". The record for this label would be for Worksheet "A600000", line 1, column 0, and formatted as below:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3A600000    1    0  TO RECLASSIFY CSS TO MED SUPPLIES
```

4021.4.4 Table 1: Worksheet Indicators

Worksheet indicators are used in the standard format to the HCFA-2552-81 (11/81) worksheet for the data. These indicators are used in the worksheet field of the formats described in Sections 4021.4.2 and 4021.4.3.

Indicator	Worksheet Title
S000001	Statistical Data - Part I
S000002	Statistical Data - Part II
S000003	Statistical Data - Part III
S000004	Statistical Data - Part IV
S000005	Statistical Data - Part V
S000006	Statistical Data - Part VI
S000007	Statistical Data - Part VII
A000000	Worksheet A
A100000	Worksheet A-1
A200001	Worksheet A-2 - Part I
A200002	Worksheet A-2 - Part II
A300000	Worksheet A-3
A400000	Worksheet A-4
A500000	Worksheet A-5

TABLE 1: WORKSHEET INDICATORS (Continued)

Indicator	Worksheet Title
A600000	Worksheet A-6
A700000	Worksheet A-7
A800000	Worksheet A-8
A81000A	Worksheet A-8-1 - Part A
A81000B	Worksheet A-8-1 - Part B
A81000C	Worksheet A-8-1 - Part C
A820000	Worksheet A-8-2
B000000	Worksheet B
B100000	Worksheet B-1
C000000	Worksheet C
D00H000	Worksheet D - Hospital
D001000	Worksheet D - Subprovider I
D002000	Worksheet D - Subprovider II
D00S000	Worksheet D - SNF
D100001	Worksheet D-1 - Part I
D100052	Worksheet D-1 - Part II - Title V
D100192	Worksheet D-1 - Part II - Title XIX
D200001	Worksheet D-2 - Part I
D200002	Worksheet D-2 - Part II
D200003	Worksheet D-2 - Part III
D30H001	Worksheet D-3 - Part I - Hospital
D301001	Worksheet D-3 - Part I - Subprovider I
D302001	Worksheet D-3 - Part I - Subprovider II
D30H002	Worksheet D-3 - Part II - Hospital
D301002	Worksheet D-3 - Part II - Subprovider I
D302002	Worksheet D-3 - Part II - Subprovider II
D30S002	Worksheet D-3 - Part II - SNF
D800001	Worksheet D-8 - Part I
D800002	Worksheet D-8 - Part II
D800003	Worksheet D-8 - Part III
D800004	Worksheet D-8 - Part IV
E000001	Worksheet E - Part I
E000002	Worksheet E - Part II

TABLE 1: WORKSHEET INDICATORS (Continued)

Indicator	Worksheet Title
E000003	Worksheet E - Part III
E10H000	Worksheet E-1 - Hospital
E101000	Worksheet E-1 - Subprovider I
E102000	Worksheet E-1 - Subprovider II
E10S000	Worksheet E-1 - SNF
E500051	Worksheet E-5 - Part I - Title V
E500191	Worksheet E-5 - Part I - Title XIX
E500052	Worksheet E-5 - Part II - Title V
E500192	Worksheet E-5 - Part II - Title XIX
E500053	Worksheet E-5 - Part III - Title V
E500193	Worksheet E-5 - Part III - Title XIX
G000000	Worksheet G
G100000	Worksheet G-1
G200001	Worksheet G-2 - Part I
G200002	Worksheet G-2 - Part II
G300000	Worksheet G-3
D400000	Worksheet D-4
D500000	Worksheet D-5
D60H001	Worksheet D-6 - Part I - Hospital
D601001	Worksheet D-6 - Part I - Subprovider I
D602001	Worksheet D-6 - Part I - Subprovider II
D60H002	Worksheet D-6 - Part II - Hospital
D601002	Worksheet D-6 - Part II - Subprovider I
D602002	Worksheet D-6 - Part II - Subprovider II
D60H003	Worksheet D-6 - Part III - Hospital
D601003	Worksheet D-6 - Part III - Subprovider I
D602003	Worksheet D-6 - Part III - Subprovider II
D700001	Worksheet D-7 - Part I
D700002	Worksheet D-7 - Part II
D700003	Worksheet D-7 - Part III
E300000	Worksheet E-3
E40H051	Worksheet E-4 - Part I - Title V - Hospital

TABLE 1: WORKSHEET INDICATORS (Continued)

Indicator	Worksheet Title
E401051	Worksheet E-4 - Part I - Title V - Subprovider I
E402051	Worksheet E-4 - Part I - Title V - Subprovider II
E40S051	Worksheet E-4 - Part I - Title V - SNF
E40H181	Worksheet E-4 - Part I - Title XVIII - Hospital
E401181	Worksheet E-4 - Part I - Title XVIII - Subprovider I
E402181	Worksheet E-4 - Part I - Title XVIII - Subprovider II
E40S181	Worksheet E-4 - Part I - Title XVIII - SNF
E40H191	Worksheet E-4 - Part I - Title XIX - Hospital
E401191	Worksheet E-4 - Part I - Title XIX - Subprovider I
E402191	Worksheet E-4 - Part I - Title XIX - Subprovider II
E40S191	Worksheet E-4 - Part I - Title XIX - SNF
E40H052	Worksheet E-4 - Part II - Title V - Hospital
E401052	Worksheet E-4 - Part II - Title V - Subprovider I
E402052	Worksheet E-4 - Part II - Title V - Subprovider II
E40S052	Worksheet E-4 - Part II - Title V - SNF
E40H182	Worksheet E-4 - Part II - Title XVIII - Hospital
E401182	Worksheet E-4 - Part II - Title XVIII - Subprovider I
E402182	Worksheet E-4 - Part II - Title XVIII - Subprovider II
E40S182	Worksheet E-4 - Part II - Title XVIII - SNF
E40H192	Worksheet E-4 - Part II - Title XIX - Hospital
E401192	Worksheet E-4 - Part II - Title XIX - Subprovider I
E402192	Worksheet E-4 - Part II - Title XIX - Subprovider II
E40S192	Worksheet E-4 - Part II - Title XIX - SNF
E40H053	Worksheet E-4 - Part III - Title V - Hospital
E401053	Worksheet E-4 - Part III - Title V - Subprovider I
E402053	Worksheet E-4 - Part III - Title V - Subprovider II
E40S053	Worksheet E-4 - Part III - Title V - SNF
E40H183	Worksheet E-4 - Part III - Title XVIII - Hospital
E401183	Worksheet E-4 - Part III - Title XVIII - Subprovider I
E402183	Worksheet E-4 - Part III - Title XVIII - Subprovider II
E40S183	Worksheet E-4 - Part III - Title XVIII - SNF
E40H193	Worksheet E-4 - Part III - Title XIX - Hospital

41

TABLE 1: WORKSHEET INDICATORS (Continued)

Indicator	Worksheet Title
E401193	Worksheet E-4 - Part III - Title XIX - Subprovider I
E402193	Worksheet E-4 - Part III - Title XIX - Subprovider II
E40S193	Worksheet E-4 - Part III - Title XIX - SNF
F000001	Worksheet F - Part I
F000002	Worksheet F - Part II
F000003	Worksheet F - Part III
A830001	Worksheet A-8-3 - Part I
A830002	Worksheet A-8-3 - Part II
A830003	Worksheet A-8-3 - Part III
A830004	Worksheet A-8-3 - Part IV
A830005	Worksheet A-8-3 - Part V
D90H000	Worksheet D-9 - Hospital
D901000	Worksheet D-9 - Subprovider I
D902000	Worksheet D-9 - Subprovider II
H000000	Worksheet H
H100000	Worksheet H-1
H200000	Worksheet H-2
H300000	Worksheet H-3
H400000	Worksheet H-4
H500001	Worksheet H-5 - Part I
H500002	Worksheet H-5 - Part II
H500003	Worksheet H-5 - Part III
H600001	Worksheet H-6 - Part I
H600002	Worksheet H-6 - Part II
H700000	Worksheet H-7
H800001	Worksheet H-8 - Part I
H800002	Worksheet H-8 - Part II
I100001	Worksheet I-1 - Part I
I100002	Worksheet I-1 - Part II
I100003	Worksheet I-1 - Part III
I100004	Worksheet I-1 - Part IV
I200000	Worksheet I-2
I300000	Worksheet I-3

NOTE: Supplemental Worksheet H Series - These worksheets are not currently required.

Supplemental Worksheet I Series - Data from Worksheet I-3, line 9, column 1 is requested. The remainder of the worksheets are not currently required.

42

4022. SUBMISSION OF MANUAL COST REPORTS

The FI must submit all Medicare cost reports to HCRIS via a timesharing system or on magnetic tape except (1) participating Indian Health Service and Veterans Administration hospitals; (2) no Medicare or low Medicare utilization cost reports filed under the provisions of HCFA-PUB 15, Part 2, Chapter 1, Sections 110A and 110B; (3) cost reports from all-inclusive rate and no-charge structure providers using cost apportionment Method B (Sliding Scale) and Method E (Percentage of Per Diem) as defined in HIM-15, Part I, Chapter 22, Section 2208; and (4) in those rare cases where a cost report cannot be put through the automated system. Prior approval must be obtained from the Regional Office (RO) before the FI can apply exception number 4. A manually prepared cost report may not be submitted merely because the FI has elected to settle a cost report as filed without review or audit.

Cost reports (representing data "as submitted" by the provider) must be reviewed by the FI to ensure: (1) that the cost report is legible; (2) that all applicable worksheets have been submitted and completed; (3) that the cost report is mathematically accurate; and (4) that the cost report data passes the HCRIS edits specified in 4023.4. All changes made as a result of the clerical desk review must be clearly noted. A legible copy of the Audit Adjustment Report and the Statement of Reimbursable Cost must be submitted with the "Final Settled" and "Reopened" Cost Reports.

The manual submissions will be subject to review after their receipt. If the manual cost report, the Audit Adjustment Report, or the Statement of Reimbursable Cost is not legible or complete, the document will be returned to the FI for resubmission. If the cost reports do not pass the edits specified in Section 4023.4, the FI will be contacted to provide correct data. For edits that are clearly mathematical errors, the corrections will be made, and the FI notified rather than requested to correct the data.

The manual cost reports may be submitted individually or batched. The manual cost reports mailed by the FI must be accompanied by a Manual Cost Report Transmission Form as presented in Exhibit 3. Cost reports must be submitted at least monthly and within the time constraints established.

A confirmation of cost report receipt will be mailed. If it is not received within 10 working days of mailing, contact: the HCRIS Project Coordinator, at Area Code (301) 594-0194.

EXHIBIT 3
MANUAL COST REPORT TRANSMISSION FORM

MAIL TO:

Health Care Financing Administration
Bureau of Data Management and Strategy
HCRIS
P.O. Box 17093
Baltimore, Maryland 21203

FI Name ____________________
FI Number ____________________
Date ____________________
Contact Person ____________________
Telephone Number ____________________

Provider Name	Provider Number	Provider FYE	Cost Report Status 1/	All Inclusive Rate Method 2/	Cost Finding Method 3/

Attach copy of math check findings (if appropriate)

Review cost report to assure all entries are legible and that all worksheets completed by the providers are attached (including financial statements) and are complete

Remarks ____________________

1/Status:
- 1 = As Submitted
- 2A = As Settled with Audit
- 2N = As Settled with No Audit
- 3 = As Reopened
- 5 = Other (Specify)

3/Cost Finding Method:
- 1 = Step Down
- 2 = Double Apportionment - Accumulative
- 3 = Double Apportionment - Non-Accumulative
- 4 = Matrix or Simultaneous Equation

2/Indicate Method: A, B, or E

4023. HCRIS DETAILED COST REPORT REQUIREMENTS AND EDITS

This section provides detailed lists of: (1) those data elements necessary to meet HCRIS' minimal reporting requirements (see Section 4023.1), including discussions of when the specified financial data are required (see Section 4023.2) and a discussion of required labeling (see Section 4023.3); (2) those data not part of the calculation for Medicare settlement which must be captured (see Section 4023.1); and (3) the edits which HCFA applies to specific data (see Section 4023.4).

4023.1 HCRIS Detailed Data Requirements.—The specific data elements necessary to meet HCRIS' minimal reporting requirements are in Table 2. All data within this list that apply to a given provider must be submitted, except as noted below and in Section 4023.2. These data must be supplied by the FI for automated cost reports, and must be included in the cost report information provided for hard copy reports.

It is necessary for the FI to ensure that these data are always reported by the provider, regardless of whether they are necessary for calculation of the Medicare settlement. The majority of these data are currently entered into an ADR system by FIs for calculation of Medicare settlement. FIs are required to provide the additional information (i.e., specified financial data from Worksheets G and G-3; those calculated fields indicated in Table 2 which are not currently input into the ADR system but are calculated by the ADR program; and required data not on the cost report such as cost report status). FIs are required to provide identifying labels for all data so that all cost center crossouts and blank lines, and changes in statistical bases, etc. can be identified. The data listed in Table 2 need only be submitted as they apply to a given provider. For data occurring in more than one location on the cost report, the data provided to HCFA can originate from any of the locations, but must always be the same as the equivalent data in other locations. 1/

In addition to the data presented in Table 2; all descriptive information required to provide complete identification of nonstandard cost centers, statistical bases, etc. (nonstandard meaning any cost center or statistical basis not preprinted on the HCFA-2552-81 (11/81)) must be provided.

1/ If there are any discrepancies for the following data items, they must be input from Worksheet D-1 rather than pages 3-4 of the cost report: Total aged, pediatric and maternity inpatient days; Total other than aged, pediatric and maternity inpatient days; Total Title XVIII aged, pediatric and maternity inpatient days; Total Title XVIII other than aged, pediatric and maternity inpatient days; and ICU, CCU, and Other Intensive Care Type Inpatient Hospital Units inpatient days and Medicare days.

45

The hard copy manual cost report submission must contain all data referenced in Table 2 applying to a given provider. These data are required to meet HCRIS minimal reporting requirements.

Note that where "All Cost Centers" are indicated with the parenthetical remark (Specify all), the request is for data for each cost center applying to a particular provider.

4023.2 Financial Data Requirements.—In Table 2, fourteen data elements are required from Worksheets G and G-3. If the provider does not submit these schedules and submits instead its balance sheet and statement of income, each required data element must be submitted only when the element can be determined from the financial information provided, without interpretation by the FI. If the provider's submission does not contain a specific requested element with the same label, that particular element need not be reported - no financial analysis is requested. If one or a few of the fourteen elements can be determined from the financial statements, report those elements and leave the others blank.

The remainder of the Worksheet G series data only need be submitted when it is currently being entered into the ADR system.

4023.3 Labeling of Cost Centers.—All data submitted via hard copy cost reports and/or automated files must be labeled such that all cost centers can be identified.

All labels needed for complete identification of nonstandard cost centers, statistical bases, etc. (nonstandard meaning any cost center or statistical basis not preprinted on the HCFA-2552-81 (11-81) cost report) must be provided by the FI. If any nonstandard labels are used, all labels must be provided. The labels must be specific and indicate cost center function. For example, if a provider has a shock therapy center called Jones Center, the proper labeling would be Shock Therapy or Jones Center Shock Therapy. Jones Center is not acceptable since the type of service cannot be determined by that title. Additionally, avoid nonstandard abbreviations or initials. The FI will be contacted if the label is not identifiable.

4023.4 Edits to be Applied.—Prior to submission, all data are to have been subjected to the following edits: (1) mathematical accuracy checks; and (2) HCRIS defined edits. (The edits to which HCFA will subject these data are indicated in the righthand column of the following pages of Table 2.) The FI will be contacted by HCFA to supply correct data for those elements failing the specified edits.

46

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
I. ITEMS FROM SOURCES OTHER THAN COST REPORT[1]							
Intermediary Number (five-digit)	X						Should be five-digit numeric
Status of Medicare Cost Report	X						1 = As submitted, after mathematical checks 2 = Settled without audit 3 = Settled with audit 4 = Reopened
Version of Cost Report	X						1 = 11/81
Intermediary Contact Person	X						
Intermediary Contact Telephone Number	X						Must be in 999-999-9999 format
Date of Transmission	X						Must be in MM/DD/YY format
Identification of All-Inclusive Provider and Type (Method A Through E)							Must be A,B,E, or N

---

[1] For hard copy cost reports, provide this information on the Manual Cost Report Transmission Form.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Type of Cost Allocation Method Used							1 = Step down 2 = Double Apportionment - Acccumulative 3 = Double Apportionment - Nonaccumulative 4 = Matrix or Simultaneous Equation 5 = Other - Specify
New Provider to Program?	X						Y or N
ADR Vendor	X						Must be present as defined in Table 3
Record Count	X						Count of all records including the identification records, data records, lablel records, and statistical records for this provider Must be numeric
Number of Interns and Residents Exemption Record							1 = SCP 2 = NP

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
II. ITEMS FROM COST REPORT							
Date Cost Report Received by FI	X		p. 2				MM/DD/YY; after ending of cost reporting period and not after current date
Hospital Provider Number			p. 2	I	1		Should be six-digit numeric or six-digits with the first five numeric and the last digit "E"
Subprovider Provider Number (Specify all)			p. 2	I	1		
Skilled Nursing Facility Provider Number			p. 2	I	1		
Home Health Agency Provider Number			p. 2	I	1		

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Cost Reporting Period —From			p. 2	I	2		
Cost Reporting Period —To			p. 2	I	2		MM/DD/YY; not before 01/01/82, not after current date
Type of Control[2/]	X		p. 2	I	3		Must be present and valid, as defined in Table 3
Type of Hospital[2/]	X		p. 2	I	4		Must be present and valid, as defined in Table 3
HOSPITAL STATISTICS							
Beds available at beginning of period (excluding newborn)							
General Service	X		p. 3	II	1	1	Greater than zero
ICU	X		p. 3	II	1	2	
CCU	X		p. 3	II	1	3	
Other Intensive Care Type Inpatient Hospital Units (Specify All)	X		p. 3	II	1		

[2/] See table 3 for valid types of control and hospital.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Beds available at end of period (excluding newborn)							
General Service	X		p. 3	II	2	1	Greater than zero
ICU	X		p. 3	II	2	2	
CCU	X		p. 3	II	2	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X		p. 3	II	2		
Total bed days available (excluding newborn)							
General Service	X		p. 3	II	3	1	Greater than zero If corresponding column of Inpatient Days is greater
ICU	X		p. 3	II	3	2	
CCU	X		p. 3	II	3	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X		p. 3	II	3		
Aged, pediatric and maternity inpatient days							
General Service	X		p. 3	II	4	1	
ICU	X		p. 3	II	4	2	
CCU	X		p. 3	II	4	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X		p. 3	II	4		

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Other than aged, pediatric and maternity inpatient days (excluding newborn)							
General Service	X		p. 3	II	5	1	
ICU	X		p. 3	II	5	2	
CCU	X		p. 3	II	5	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X		p. 3	II	5		
Total inpatient days (excluding newborn)							
General Service	X	X	p. 3	II	6	1	Less than or equal to corresponding column of Total Bed Days, above
ICU	X	X	p. 3	II	6	2	
CCU	X	X	p. 3	II	6	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X	X	p. 3	II	6		
Title XVIII - Total aged, pediatric and maternity inpatient days							
General Service	X	X	p. 3	II	10c	1	
ICU	X	X	p. 3	II	10c	2	
CCU	X	X	p. 3	II	10c	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X	X	p. 3	II	10c		

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Total XVIII - Total other than aged, pediatric, and maternity inpatient days							
General Service	X	X	p. 3	II	10f	1	
ICU	X	X	p. 3	II	10f	2	
CCU	X	X	p. 3	II	10f	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X	X	p. 3	II	10f		
Title XVIII - Total Part A inpatient days							
General Service	X	X	p. 3	II	10i	1	Less than or equal to corresponding column of Total Inpatient Days, above
ICU	X	X	p. 3	II	10i	2	
CCU	X	X	p. 3	II	10i	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X	X	p. 3	II	10i		
Title XVIII - Total Part B inpatient days							
General Service	X		p. 3	II	10j	1	Less than or equal to corresponding column of Total Inpatient Days, above
ICU	X		p. 3	II	10j	2	
CCU	X		p. 3	II	10j	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X		p. 3	II	10j		

53

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Title XVIII - Part B inpatient days when Part A benefits are not available							
General Service	X		p. 3	II	10k	1	
ICU	X		p. 3	II	10k	2	
CCU	X		p. 3	II	10k	3	
Other Intensive Care Type Inpatient Hospital Units (Specify all)	X		p. 3	II	10k		
Number of occasions of service (exclusive of renal dialysis treatment)							
Title XVIII	X		p. 3	II	12	2	
Total	X	X	p. 3	II	12	5	
OTHER HOSPITAL DATA							
Average number of employees on on payroll for the period (FTE) - excludes non-paid workers	X		p. 3	III	2		Greater than zero
Average number of non-paid workers for the period (FTE) for which reimbursement is claimed	X		p. 3	III	3		

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Number of admissions (excluding newborn)							
Total	X		p. 3	III	5a		Less than or equal to Total Inpatient Days, above
Title XVIII	X		p. 3	III	5c		Less than or equal to Total Inpatient Days, above
Number of discharges including deaths (excluding newborn)							
Total	X		p. 3	III	6a		
Title XVIII	X		p. 3	III	6c		Less than or equal to Total Discharges, above
SUBPROVIDER AND SKILLED NURSING FACILITY STATISTICS							
Beds available at beginning of period (excluding newborn)							
All Subproviders (Specify all)	X		p. 4	IV	1		
SNF-Certified	X		p. 4	IV	1	3	
Beds available at end of period (excluding newborn)							
All Subproviders (Specify all)	X		p. 4	IV	2		
SNF-Certified	X		p. 4	IV	2	3	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Total beds available (excluding newborn)							
All Subproviders (Specify all)	X		p. 4	IV	3		If Total Inpatient Days is greater than zero, should be greater than zero
Aged, pediatric, and maternity inpatient days							
All Subproviders (Specify all)	X		p. 4	IV	4		
SNF-Certified	X		p. 4	IV	4	3	
SNF-Noncertified	X		p. 4	IV	4	4	
Other than aged, pediatric, and maternity inpatient days (excluding newborn)							
All Subproviders (Specify all)	X		p. 4	IV	5		
SNF-Certified	X		p. 4	IV	5	3	
SNF-Noncertified	X		p. 4	IV	5	4	
Total inpatient days (excluding newborn)							
All Subproviders (Specify all)	X	X	p. 4	IV	6		Less than or equal to Total Bed Days, above
SNF-Certified	X	X	p. 4	IV	6	3	
SNF-Noncertified	X	X	p. 4	IV	6	4	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Title XVIII - Total aged, pediatric, and maternity inpatient days							
All Subproviders (Specify all)	X	X	p. 4	IV	10c		
SNF-Certified	X	X	p. 4	IV	10c	3	
Title XVIII - Total other than aged pediatric, and maternity inpatient days							
All Subproviders (Specify all)	X	X	p. 4	IV	10f		
SNF-Certified	X	X	p. 4	IV	10f	3	
Title XVIII - Total Part A inpatient days							
All Subproviders (Specify all)	X	X	p. 4	IV	10i		Less than or equal to Total Inpatient Days, above
SNF-Certified	X	X	p. 4	IV	10i	3	
OTHER SUBPROVIDER AND SKILLED NURSING FACILITY DATA							
Average number of employees on payroll for the period (FTE) - excludes non-paid workers							
All Subproviders (Specify all)	X		p. 4	V	2		If Total Inpatient Days is greater than zero, should be greater than zero
SNF-Certified	X		p. 4	V	2	3	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Average number of non-paid workers for the period (FTE) for which reimbursement is claimed							
All Subproviders (Specify all)	X		p. 4	V	3		
SNF-Certified	X		p. 4	V	3	3	
Number of admissions (excluding newborn) - Total							
All Subproviders (Specify all)	X		p. 4	V	6a		If Total Inpatient Days is greater than zero, should be greater than zero
SNF-Certified	X		p. 4	V	6a	3	
Number of admissions (excluding newborn) - Title XVIII							
All Subproviders (Specify all)	X		p. 4	V	6c		Less than or equal to Total Admissions, above
SNF-Certified	X		p. 4	V	6c	3	
Number of discharges including deaths (excluding newborn) - Total							
All Subproviders (Specify all)	X		p. 4	V	7A		
SNF-Certified	X		p. 4	V	7a	3	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Number of discharges including deaths (excluding newborn) - Title XVIII							
All Subproviders (Specify all)	X		p. 4	V	7c		Less than or equal to Total Discharges, above
SNF-Certified	X		p. 4	V	7c	3	
HOME HEALTH AGENCY STATISTICS							
HHA Visits - Skilled Nursing							
Title XVIII - Visits	X		p. 5	VI	1a	1	
Title XVIII - Patients	X		p. 5	VI	1a	2	
Other - Visits	X		p. 5	VI	1a	3	
Other - Patients	X		p. 5	VI	1a	4	
HHA Visits - Physical Therapy							
Title XVIII - Visits	X		p. 5	VI	1b	1	
Title XVIII - Patients	X		p. 5	VI	1b	2	
Other - Visits	X		p. 5	VI	1b	3	
Other - Patients	X		p. 5	VI	1b	4	
HHA Visits - Speech Pathology							
Title XVIII - Visits	X		p. 5	VI	1c	1	
Title XVIII - Patients	X		p. 5	VI	1c	2	
Other - Visits	X		p. 5	VI	1c	3	
Other - Patients	X		p. 5	VI	1c	4	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
HHA Visits - Occupational Therapy							
Title XVIII - Visits	X		p. 5	VI	1d	1	
Title XVIII - Patients	X		p. 5	VI	1d	2	
Other - Visits	X		p. 5	VI	1d	3	
Other - Patients	X		p. 5	VI	1d	4	
HHA Visits - Medical Social Service							
Title XVIII - Visits	X		p. 5	VI	1e	1	
Title XVIII - Patients	X		p. 5	VI	1e	2	
Other - Visits	X		p. 5	VI	1e	3	
Other - Patients	X		p. 5	VI	1e	4	
HHA Visits - Home Health Aide							
Title XVIII - Visits	X		p. 5	VI	1f	1	
Title XVIII - Patients	X		p. 5	VI	1f	2	
Other - Visits	X		p. 5	VI	1f	3	
Other - Patients	X		p. 5	VI	1f	4	
HHA Visits - All Other Services							
Other - Visits	X		p. 5	VI	1g	3	
Other - Patients	X		p. 5	VI	1g	4	
Unduplicated Census Count							
Title XVIII	X		p. 5	VI	1i	1	
Other	X		p. 5	VI	1i	3	
Home Health Aide Hours							
Title XVIII	X		p. 5	VI	1j	1	
Other	X		p. 5	VI	1j	3	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Number of Hours in Normal Work Week	X		p. 5	VI	2		
HHA - Number of Employees (FTE) - Administrator and Assistant Administrators							
Staff	X		p. 5	VI	2a	1	
Contract	X		p. 5	VI	2a	2	
HHA - Number of Employees (FTE) - Directors and Assistant Directors							
Staff	X		p. 5	VI	2b	1	
Contract	X		p. 5	VI	2b	2	
HHA - Number of Employees (FTE) - Other Administrative Personnel							
Staff	X		p. 5	VI	2c	1	
Contract	X		p. 5	VI	2c	2	
HHA - Number of Employees (FTE) - Direct Nursing Service							
Staff	X		p. 5	VI	2d	1	
Contract	X		p. 5	VI	2d	2	
HHA - Number of Employees (FTE) - Nursing Supervisor							
Staff	X		p. 5	VI	2e	1	
Contract	X		p. 5	VI	2e	2	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
HHA - Number of Employees (FTE) - Physical Therapy Service							
Staff	X		p. 5	VI	2f	1	
Contract	X		p. 5	VI	2f	2	
HHA - Number of Employees (FTE) - Physical Therapy Supervisor							
Staff	X		p. 5	VI	2g	1	
Contract	X		p. 5	VI	2g	2	
HHA - Number of Employees (FTE) - Speech Pathology Service							
Staff	X		p. 5	VI	2h	1	
Contract	X		p. 5	VI	2h	2	
HHA - Number of Employees (FTE) - Speech Pathology Supervisor							
Staff	X		p. 5	VI	2i	1	
Contract	X		p. 5	VI	2i	2	
HHA - Number of Employees (FTE) - Occupational Therapy Service							
Staff	X		p. 5	VI	2j	1	
Contract	X		p. 5	VI	2j	2	

62

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
HHA - Number of Employees (FTE) - Occupational Therapy Supervisor							
Staff	X		p. 5	VI	2k	1	
Contract	X		p. 5	VI	2k	2	
HHA - Number of Employees (FTE) - Medical Social Service							
Staff	X		p. 5	VI	2l	1	
Contract	X		p. 5	VI	2l	2	
HHA - Number of Employees (FTE) - Medical Social Service Supervisor							
Staff	X		p. 5	VI	2m	1	
Contract	X		p. 5	VI	2m	2	
HHA - Number of Employees (FTE) - Home Health Aide							
Staff	X		p. 5	VI	2n	1	
Contract	X		p. 5	VI	2n	2	
HHA - Number of Employees (FTE) - Home Health Aide Supervisor							
Staff	X		p. 5	VI	2o	1	
Contract	X		p. 5	VI	2o	2	
HHA - Number of Employees (FTE) - Other (Specify)							
Staff	X		p. 5	VI		1	
Contract	X		p. 5	VI		2	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
RENAL DIALYSIS DEPARTMENT STATISTICS							
Type of Physician Reimbursement Method	X		p. 5	VII	1		As defined in Table 3
If Alternative Method, indicate Date for Election for Alternative Method	X		p. 5	VII	1		MM/DD/YY
Number of Treatments Not Billed to Medicare and Furnished Directly							
Outpatient - Hemodialysis	X		p. 5	VII	1a	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1a	2	
Training - Hemodialysis	X		p. 5	VII	1a	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1a	4	
Number of Treatments Not Billed to Medicare and Furnished Under Arrangements							
Outpatient - Hemodialysis	X		p. 5	VII	1b	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1b	2	
Training - Hemodialysis	X		p. 5	VII	1b	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1b	4	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Average times per week patient receives dialysis							
Outpatient - Hemodialysis	X		p. 5	VII	1c	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1c	2	
Training - Hemodialysis	X		p. 5	VII	1c	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1c	4	
Number of days in an average week for patient dialysis treatments							
Outpatient - Hemodialysis	X		p. 5	VII	1d	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1d	2	
Training - Hemodialysis	X		p. 5	VII	1d	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1d	4	
Average time of patient dialysis treatment including set up time							
Outpatient - Hemodialysis	X		p. 5	VII	1e	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1e	2	
Training - Hemodialysis	X		p. 5	VII	1e	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1e	4	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Number of machines regularly available for use							
Outpatient - Hemodialysis	X		p. 5	VII	1f	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1f	2	
Training - Hemodialysis	X		p. 5	VII	1f	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1f	4	
Number of standby machines							
Outpatient - Hemodialysis	X		p. 5	VII	1g	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1g	2	
Training - Hemodialysis	X		p. 5	VII	1g	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1g	4	
Machine time used in typical week during regular reporting period per shift							
Outpatient - Hemodialysis	X		p. 5	VII	1h	1	
Outpatient - Peritoneal Dialysis	X		p. 5	VII	1h	2	
Training - Hemodialysis	X		p. 5	VII	1h	3	
Training - Peritoneal Dialysis	X		p. 5	VII	1h	4	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Type of dialyzers used	X		p. 5	VII	1i		
If dialyzers are reused, indicate number of times	X		p. 5	VII	1i		
Number of back-up sessions furnished to home patients							
CAPD	X		p. 5	VII	1j	1	
Other	X		p. 5	VII	1j	2	
Is Home Program Dialysis reimbursed under Target Rate Election?	X		p. 5	VII	1k		Y or N
Type of Home Program dialyzers used	X		p. 5	VII	1l		
If dialyzers are reused, indicate number of times	X		p. 5	VII	1l		
Number of hours in normal work week	X		p. 5	VII	2		
Renal Dialysis Department - Number of Employees (FTE) - Physicians							
Staff	X		p. 5	VII	2a	1	
Contract	X		p. 5	VII	2a	2	
Other	X		p. 5	VII	2a	3	

67

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Renal Dialysis Department - Number of Employees (FTE) - Registered Nurses							
Staff	X		p. 5	VII	2b	1	
Contract	X		p. 5	VII	2b	2	
Other	X		p. 5	VII	2b	3	
Renal Dialysis Department - Number of Employees (FTE) - Licensed Practical Nurses							
Staff	X		p. 5	VII	2c	1	
Contract	X		p. 5	VII	2c	2	
Other	X		p. 5	VII	2c	3	
Renal Dialysis Department Number of Employees (FTE) - Nurses Aides							
Staff	X		p. 5	VII	2d	1	
Contract	X		p. 5	VII	2d	2	
Other	X		p. 5	VII	2d	3	
Renal Dialysis Department - Number of Employees (FTE) - Technicians							
Staff	X		p. 5	VII	2e	1	
Contract	X		p. 5	VII	2e	2	
Other	X		p. 5	VII	2e	3	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Renal Dialysis Department - Number of Employees (FTE) - Social Workers							
Staff	X		p. 5	VII	2f	1	
Contract	X		p. 5	VII	2f	2	
Other	X		p. 5	VII	2f	3	
Renal Dialysis Department - Number of Employees (FTE) - Dieticians							
Staff	X		p. 5	VII	2g	1	
Contract	X		p. 5	VII	2g	2	
Other	X		p. 5	VII	2g	3	
Renal Dialysis Department - Number of Employees (FTE) - Administrative							
Staff	X		p. 5	VII	2h	1	
Contract	X		p. 5	VII	2h	2	
Other	X		p. 5	VII	2h	3	
Renal Dialysis Department - Number of Employees (FTE) - Management							
Staff	X		p. 5	VII	2i	1	
Contract	X		p. 5	VII	2i	2	
Other	X		p. 5	VII	2i	3	
Renal Dialysis Department - Number of Employees (FTE) - Other (Specify)							
Staff	X		p. 5	VII		1	
Contract	X		p. 5	VII		2	
Other	X		p. 5	VII		3	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES - WORKSHEET A							
Depreciation - Buildings and Fixtures 3/							
Other Expenses			A		2	2	
Reclassifications		X	A		2	4	
Depreciation - Movable Equipment 3/							
Other Expenses			A		3	2	
Reclassifications		X	A		3	4	
All Cost Centers (Specify all)							
Salaries			A		4-83	1	
Other Expenses			A		4-83	2	
Intern-Resident Service (in approved teaching program) (Specify all) 3/							
Reclassifications		X	A		19	4	
Malpractice premiums and paid losses 3/							
Reclassifications		X	A		71	4	

[3/] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
RECLASSIFICATIONS AFFECTING ADMINISTRATIVE AND GENERAL EXPENSES - WORKSHEET A-1							
Worksheet A-1—All non-calculated items necessary for reimbursement			A-1				
Interest Interest Expense			A-1		15	5	
Total Reclassifications Administrative and General		X	A-1		19	4	
RECLASSIFICATIONS OF DIETARY EXPENSE - WORKSHEET A-2							
Worksheet A-2—All non-calculated items necessary for reimbursement			A-2				
Dietary Analysis of Dietary Expenses			A-2	I	2	2	
Cafeteria Analysis of Dietary Expenses			A-2	I	3	2	
Other Dietary Expenses (Specify all) Analysis of Dietary Expenses			A-2	I		2	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
RECLASSIFICATION OF CENTRAL SERVICES AND SUPPLY - WORKSHEET A-3							
Worksheet A-3—All non-calculated items necessary for reimbursement			A-3				
RECLASSIFICATION OF LABORATORY EXPENSE - WORKSHEET A-4							
Worksheet A-4—All non-calculated items necessary for reimbursement			A-4				
RECLASSIFICATION OF RADIOLOGY DIAGNOSTIC - WORKSHEET A-5							
Worksheet A-5—All non-calculated items necessary for reimbursement			A-5				
RECLASSIFICATIONS - OTHER - WORKSHEET A-6							
Worksheet A-6—All non-calculated items necessary for reimbursement			A-6				

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES QUESTIONNAIRE - WORKSHEET A-7							
Land							
Beginning Balance	X		A-7		1	1	
Purchase	X		A-7		1	2	
Donation	X		A-7		1	3	
Disposals and Retirements	X		A-7		1	5	
Land Improvements							
Beginning Balance	X		A-7		1	1	
Purchase	X		A-7		1	2	
Donation	X		A-7		1	3	
Disposals and Retirements	X		A-7		1	5	
Buildings and Fixtures							
Beginning Balance	X		A-7		1	1	
Purchase	X		A-7		1	2	
Donation	X		A-7		1	3	
Disposals and Retirements	X		A-7		1	5	
Building Improvements							
Beginning Balance	X		A-7		1	1	
Purchase	X		A-7		1	2	
Donation	X		A-7		1	3	
Disposals and Retirements	X		A-7		1	5	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Equipment-Fixed							
Beginning Balance	X		A-7		1	1	
Purchase	X		A-7		1	2	
Donation	X		A-7		1	3	
Disposals and Retirements	X		A-7		1	5	
Equipment-Movable							
Beginning Balance	X		A-7		1	1	
Purchase	X		A-7		1	2	
Donation	X		A-7		1	3	
Disposals and Retirements	X		A-7		1	5	
Were there any obligations and/or expenditures incurred for capital expenditures by or on behalf of the provider?	X		A-7		2		Y or N
Capital Expenditure Data (Specify all)							
Description	X		A-7		3		
How acquired	X		A-7		3	1	
Date obligation incurred	X		A-7		3	2	MM/DD/YY
Cost	X		A-7		3	3	
Depreciation	X		A-7		3	4	
Interest	X		A-7		3	5	
Rent	X		A-7		3	6	
Other Expense	X		A-7		3	7	
Other Amount	X		A-7		3	8	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Written notice of intention to make capital expenditure (Specify all)							
Description	X		A-7		4		
Date written notice submitted	X		A-7		4	1	MM/DD/YY
Date approved	X		A-7		4	2	MM/DD/YY
Date notice of disapproval received	X		A-7		4	3	MM/DD/YY
Date of appeal of denial	X		A-7		4	4	MM/DD/YY
Status of appeal	X		A-7		4	5	
ADJUSTMENTS TO EXPENSES - WORKSHEET A-8							
Worksheet A-8—All non-calculated items necessary for reimbursement			A-8				
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS - WORKSHEET A-8-1							
Are there any costs included on Worksheet A which resulted from transactions with related organizations?	X		A-8-1	A	1		Y or N

75

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Costs incurred and adjustment required as a result of transactions with related organizations (Specify all)							
Line No.			A-8-1	B		1	
Cost center			A-8-1	B		2	
Expense items			A-8-1	B		3	
Amount			A-8-1	B		4	
Amount allowable in cost			A-8-1	B		5	
Interrelationship of provider to related organizations (Specify all)							
Symbol	X		A-8-1	C		1	
Name	X		A-8-1	C		2	
Percent of ownership of provider	X		A-8-1	C		3	
Name of related organization	X		A-8-1	C		4	
Percent of ownership	X		A-8-1	C		5	
Type of business	X		A-8-1	C		6	
DEPRECIATION - WORKSHEET A-8-2							
Is depreciation funded?	X		A-8-2		2		Y or N
If yes: Balance in fund at end of period	X		A-8-2		2		

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
COST ALLOCATION - GENERAL SERVICE COSTS - WORKSHEET B							
All Cost Centers (Specify all) Net expenses (before stepdown)		X	B		2-78	1	
Nursing School 3/ (after stepdown 4/)		X	B		18	18	
Intern-Resident Service (in approved teaching program) 3/ (after stepdown 4/) (Specify all)		X	B		19	19	
Other approved teaching and supervisory physicians program 3/ (after stepdown 4/) (Specify all)		X	B				
All Non-General Service Cost Centers (Specify all) Total (after stepdown 4/)		X	B		22-78	21	

[3/] These cost centers need only be present as applicable.

[4/] For double, multiple, or matrix apportionment, use the sum of all passes of apportionment.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Operating Room[3/]							
Depreciation - Buildings and Fixtures		X	B		22	2	
Depreciation - Movable Equipment		X	B		22	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		22	19	
Recovery Room[3/]							
Depreciation - Buildings and Fixtures		X	B		23	2	
Depreciation - Movable Equipment		X	B		23	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		23	19	
Delivery Room and Labor Room[3/]							
Depreciation - Buildings and Fixtures		X	B		24	2	
Depreciation - Movable Equipment		X	B		24	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		24	19	

[3/] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Anesthesiology[3]							
Depreciation - Buildings and Fixtures		X	B		25	2	
Depreciation - Movable Equipment		X	B		25	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		25	19	
Radiology - Diagnostic[3]							
Depreciation - Buildings and Fixtures		X	B		26	2	
Depreciation - Movable Equipment		X	B		26	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		26	19	
Radiology - Therapeutic[3]							
Depreciation - Buildings and Fixtures		X	B		27	2	
Depreciation - Movable Equipment		X	B		27	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		27	19	

---

[3] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Radioisotope[3]							
Depreciation - Buildings and Fixtures		X	B		28	2	
Depreciation - Movable Equipment		X	B		28	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		28	19	
Laboratory[3]							
Depreciation - Buildings and Fixtures		X	B		29	2	
Depreciation - Movable Equipment		X	B		29	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		29	19	
Whole Blood and Packed Red Blood Cells[3]							
Depreciation - Buildings and Fixtures		X	B		30	2	
Depreciation - Movable Equipment		X	B		30	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		30	19	

---

[3] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Blood Storing, Processing and Transfusion[3]							
Depreciation - Buildings and Fixtures		X	B		31	2	
Depreciation - Movable Equipment		X	B		31	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		31	19	
Intravenous Therapy[3]							
Depreciation - Buildings and Fixtures		X	B		32	2	
Depreciation - Movable Equipment		X	B		32	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		32	19	
Oxygen (Inhalation) Therapy[3]							
Depreciation - Buildings and Fixtures		X	B		33	2	
Depreciation - Movable Equipment		X	B		33	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		33	19	

---

[3] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Physical Therapy[3]							
Depreciation - Buildings and Fixtures		X	B		34	2	
Depreciation - Movable Equipment		X	B		34	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		34	19	
Occupational Therapy[3]							
Depreciation - Buildings and Fixtures		X	B		35	2	
Depreciation - Movable Equipment		X	B		35	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		35	19	
Speech Pathology[3]							
Depreciation - Buildings and Fixtures		X	B		36	2	
Depreciation - Movable Equipment		X	B		36	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		36	19	

---

[3] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Electrocardiology[3]							
Depreciation - Buildings and Fixtures		X	B		37	2	
Depreciation - Movable Equipment		X	B		37	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		37	19	
Electroencephalography[3]							
Depreciation - Buildings and Fixtures		X	B		38	2	
Depreciation - Movable Equipment		X	B		38	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		38	19	
Medical Supplies Charged to Patients[3]							
Depreciation - Buildings and Fixtures		X	B		39	2	
Depreciation - Movable Equipment		X	B		39	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		39	19	

---

[3] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Drugs Charged to Patients[3/]							
Depreciation - Buildings and Fixtures		X	B		40	2	
Depreciation - Movable Equipment		X	B		40	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		40	19	
Renal Dialysis[3/]							
Depreciation - Buildings and Fixtures		X	B		41	2	
Depreciation - Movable Equipment		X	B		41	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		41	19	
Kidney Acquisition[3/]							
Depreciation - Buildings and Fixtures		X	B		42	2	
Depreciation - Movable Equipment		X	B		42	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		42	19	

[3/] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
All Other Ancillary Cost Centers 3/ (Specify all)							
Depreciation - Buildings and Fixtures		X	B			2	
Depreciation - Movable Equipment		X	B			3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B			19	
Adults and Pediatrics (General Routine Care)							
Depreciation - Buildings and Fixtures		X	B		46	2	
Depreciation - Movable Equipment		X	B		46	3	
Nursing School		X	B		46	18	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		46	19	
Other approved teaching and supervisory physicians program - as applicable		X	B		46		

3/ These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Intensive Care Units[3]							
Depreciation - Buildings and Fixtures		X	B		47	2	
Depreciation - Movable Equipment		X	B		47	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		47	19	
Coronary Care Units[3]							
Depreciation - Buildings and Fixtures		X	B		48	2	
Depreciation - Movable Equipment		X	B		48	3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		48	19	
All Other Intensive Care Type Inpatient Hospital Unit Cost Centers 3/ (Specify all)							
Depreciation - Buildings and Fixtures		X	B			2	
Depreciation - Movable Equipment		X	B			3	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B			19	

---

[3] These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Subproviders (Specify all)3/							
Nursing school		X	B			18	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B			19	
Other approved teaching and supervisory physicians program - as applicable		X	B				
Skilled Nursing Facility - Certified 3/							
Nursing School		X	B		52	18	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		52	19	
Other approved teaching and supervisory physicians program - as applicable		X	B		52		
Skilled Nursing Facility - Noncertified 3/							
Nursing School		X	B		53	18	
Intern-Resident Service (in approved teaching program) (Specify all)		X	B		53	19	
Other approved teaching and supervisory physicians program - as applicable		X	B		53		

3/These cost centers need only be present as applicable.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
COST ALLOCATION - STATISTICAL BASIS - WORKSHEET B-1							
All Cost Centers (Specify all)							
All Statistical Bases 5/			B-1				
DEPARTMENTAL COST DISTRIBUTION - WORKSHEET C							
All Cost Centers (Specify all) 5/							
Total Charges			C		2b-29b	1	
Hospital Inpatient Charges			C		2b-29b	3	
Subprovider Inpatient Charges (Specify all)			C		2b-29b	4 or 5	
SNF-Certified Inpatient Charges			C		2b-29b	6	
Title XVIII - Part B 100% Outpatient Charges			C		2b-29b	7	
Title XVIII - Part B Outpatient Emergency Service Charges			C		2b-29b	8	
Title XVIII - Renal Dialysis Outpatient Charges			C		2b-29b	9	

---

[5] Specify only the detail that applies to a particular cost center.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Title XVIII - Part B							
All Other Outpatient Charges			C		2b-29b	10	
Title XVIII - Kidney Acquisition							
Outpatient Charges			C		2b-29b	11	
Renal Dialysis Other Outpatient Charges			C		2b-29b	12	
Medical Emergency Other Outpatient Charges			C		2b-29b	13	
All Other Outpatient Charges			C		2b-29b	14	
Home Health Agency Charges			C		2b-29b	15	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICES TO HEALTH CARE PROGRAMS - WORKSHEET D							
All Cost Centers (Specify all)[5]							
Title XVIII Part A							
Inpatient Charges			D		2-27	3	
Title XVIII Part B							
Inpatient Charges			D		2-27	4	

---

[5] Specify only the detail that applies to a particular cost center.

4100. AUDIT - GENERAL

Providers receiving payments under Parts A and B of title XVIII of the Social Security Act, as amended, are subject to audit for all payments applicable to services rendered to Medicare beneficiaries. The audit is made to insure that proper payments were made on the basis of reasonable costs of covered services, to provide verified financial information for making a final determination of allowable costs, to discover any possible instances of fraud and abuse, and to develop such other information as the Health Care Financing Administration (HCFA) may need to fulfill its responsibilities under the Medicare program. This manual establishes audit requirements and includes guidelines for use in performing audits that fulfill these requirements.

4100.1 Intermediary's Responsibilities.—In carrying out your contractual responsibilities for assuring that proper payments are made, determine (1) on an individual provider basis, whether audit is necessary, and (2) where audit is considered necessary, the scope of audit appropriate under the circumstances. The basis for each decision must be recorded.

Regardless of the method employed to accomplish provider audits, annual audit plans and priorities must be formulated and adhered to in making audit decisions. HCFA must be consulted on changes in audit policies, procedures, plans and priorities. In addition, a qualified staff must be available to adequately perform the duties attendant to the audit functions.

4100.2 Definitions.—

A. Desk Review.—The desk review is an analysis of the provider cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, and a summary of results of review for the purpose of either settling the cost report without field audit or determining the extent to which field audit verification is to be required.

The desk review consists of the following functions:

1. Clerical review —
    a. Determination of the completeness of the cost report,
    b. Verification of the mathematical accuracy of the cost report,
    c. Entry of cost report data into an automated data base where the fiscal intermediary uses an automated desk review system,
    d. Preparation of prior year and current year cost report data comparison formats when they are needed for the professional review;
2. Professional preview (See section 4104.1); and

3. Professional review --

a. Determination of whether to perform a field audit and the scope of such audit based on a variety of factors and steps which may include, but are not limited to

(1) Comparison of prior year and current year cost report data,

(2) Followup on corrective actions on deficiencies noted from prior desk review and/or field audit,

(3) Reasonable cost determination by comparison with published limits and established guidelines,

(4) Determination of inconsistencies in the application of generally accepted accounting principles and Medicare program policies and procedures,

(5) Determination of the existence of reasonable support for cost and statistical data based on prior experience,

b. Summarization of findings regarding whether to field audit and the scope of such audit and

c. Summarization of issues and findings for subsequent year desk reviews.

The desk review, according to the standards promulgated by the Comptroller General of the United States, is a survey. It is a process to review information, without detailed verification, on the provider and is designed to identify problem areas warranting additional review and to obtain information for use in planning and accomplishing the field audit.

B. Field Audit.—A field audit is the performance of prescribed procedures to be followed in the examination and verification of data maintained by the provider and designed to fulfill the audit objectives within the established scope of work. The audit encompasses a written record of the work performed and the results thereof. The field audit includes:

1. An examination of statistical and financial transactions, accounts and reports including an evaluation of compliance with applicable laws and regulations.

2. A review of efficiency and economy in the use of resources.

3. A review to determine whether desired results are effectively achieved.

Audits on the Medicare cost reports are limited to financial and compliance audits as described in (1) above.

C. Abuse.—An abuse is the administrative violation of agency regulations which impair the effective and efficient execution of the program. These violations may result in Federal losses or they may result in denial or reduction in lawfully authorized benefits to participants. None of these involve prosecutable fraud.

D. Fraud.—Fraud is obtaining something of value, unlawfully, through willful misrepresentation. It embraces theft, embezzlement, false statements, illegal commissions, kickbacks, conspiracies, obtaining contracts through collusive arrangements and similar devices.

4104. AUDIT WORK PLAN AND SELECTION PROCESS

The audit work plan and selection process is influenced by the budgetary restrictions imposed on the intermediary and the findings from the professional preview and/or the professional desk review. Audit work will be established according to the instructions provided for in the Audit Priority Matrix (see section 4013), and must be adhered to except upon advising the regional office of the need for changes and upon obtaining regional office concurrence. Progress made by operating under the audit work plan and the desk review activities should be monitored to determine whether the desired results are being achieved.

4104.1 Professional Preview.—The professional preview is a preliminary analysis of the cost report and the provider's background to determine whether any further desk review, or ultimately, field audit is necessary. It is intended to create and document an immediate awareness for changes, open issues and referrals. The reviewer will have available for the professional preview the following items:

Cost Report
Questionnaire on Changes in Provider's Operations
Provider Permanent Reference File
Working Trial Balance
Financial Statements
Prior Year's Audit Notes
Prior Year's Audit Adjustments
Current Appeal Issues

The process begins after the cost report has been received, reviewed for completeness and accepted. The cost report should be assigned to a highly experienced professional accountant to perform the professional preview. The clerical desk review may be performed before the professional reviewer is furnished the cost report or at any other point before final settlement that the fiscal intermediary deems appropriate.

Questionnaires on changes in provider's operations are used to update the permanent reference file. (Presently, fiscal intermediaries use a variety of questionnaires of their own design which have been approved for use by the Office of Management and Budget. These questionnaires should be used until HCFA issues a standard questionnaire.)

Whenever a change does occur, the provider submits a copy of the appropriate supporting documentation according to the submission requirements established with the intermediary. In this way the intermediary is alerted to changes occurring at the provider which impact reimbursement. The professional reviewer will use the questionnaire to become more familiar with the provider's operation and general profile and to more effectively identify problem areas and determine the direction of the desk review or field audit, if necessary.

The Provider Reimbursement Manual, Part II (HCFA Pub. 15-II), section 306, requires all providers filing cost reports on form HCFA-2552 to submit a copy of the working trial balance which links the cost report with the provider's accounting records and financial statements. The reviewer will scan the working trial balance looking for many types of indicators. As a minimum, the working trial balance may disclose:

1. New or deleted accounts
2. Cost and revenue trends
3. Cost and revenue shifts
4. Changes in account structure
5. Changes in cost center structure
6. Misapplication of reimbursement principles

These and many more possible financial disclosures will furnish the reviewer with a basis for determining the need for additional indepth analysis.

Where financial statements are available, they may serve as a direct source for identifying problem areas in the current cost report. The review process is a search for compliance in applying the principles of reimbursement. The following represents a general outline of possible review areas.

1. In the Notes to the Financial Statements search for any unusual items or changes in accounting policy.

2. In the certification of the auditor, if applicable, review the qualification of the auditor's opinion for items that may have cost reimbursement implication.

3. Review for the large variances over the prior period which may impact on reimbursement and/or that are not related to patient care.

4. Review long term liabilities in comparison with the assets for any significant imbalance between the two (if assets are much higher, how were they financed, or if a liability may be omitted, etc.).

5. Review for material differences in funding statements (e.g., any sale of fixed assets and any gain/loss resulting thereof).

6. Review transfers of restricted funds to unrestricted funds to reconcile with additions to property, plant or equipment financed by restricted funds.

The professional reviewer will consider prior year's audit referrals and prior year's audit adjustments for possible applicability to the current cost report. The purpose is to review the prior year's audit notes and adjustments for awareness and to decide if these are applicable to the current year cost report, if they are identifiable in the cost report and if they are properly reflected there.

The appeal issues to be considered are both those in which the provider is currently involved and national and/or group appeal issues in which the provider is not currently a party but could possibly apply. The reviewer will decide after reviewing the current cost report if the appealed cost items are correctly treated.

After considering all of the foregoing and properly documenting the analyses through brief notations of potential exceptions, the reviewer must make a decision about the next step to be performed on the cost report. This decision is influenced by the budgetary audit priorities.

4104.2 Audit Priority Considerations.—One or more of the audit priority considerations may enter into the decision to audit, the degree to which audit coverage is to be given and the scope of each type of audit coverage. Conversely, selected cost reports may require an audit even though other considerations are not satisfied. The audit priority matrix (see section 4013) will array these considerations for each type or groupings of providers. When the predetermined circumstances occur, the intermediary decides the need to audit and the extent to which audit coverage is necessary by referring to the work plan. The circumstances and characteristics that must be considered during the development of the audit work plan and at the point of making the audit decision are described below. These considerations will be weighted and laid out in the audit priority matrix. These are not prioritized, nor all inclusive, and some may not be completely defined until the formulation of the work plan.

1. New Provider or Change in Intermediary.—The first cost report filed by a provider that is new to the program or new to the intermediary as a result of changing intermediaries generally should be audited. This gives the intermediary a basis from which to review and evaluate subsequent years' cost reports. The audit of a cost report from a provider that changes intermediaries will be:

(a) limited to those issues, if any, pending from prior cost report examinations in the case of the intermediary closing its final cost report; or

(b) performed to the extent necessary to supplement information received from the prior intermediary in the case of the intermediary examining its first cost report.

2. Significance of Total Medicare Program Payments.—Large providers, with significant Medicare reimbursement, are generally the most cost beneficial audits to perform due to potential for major audit adjustments.

3. Cost Benefit.—The prevailing consideration behind the criteria for selecting audits is generally cost benefit. This, however, is not always determinable prior to audit.

4. Types of Providers.—Special attention may be required for certain types of providers because of known or anticipated problems or circumstances.

5. Conditions and Occurrences at the Provider.—

a. Change in ownership or termination from the program

b. Significant change in personnel or organization

c. Intermediary's prior experience especially with the condition of the provider's records or reporting habits

d. Overpayment prior and/or current year

e. Interim rate high compared to other comparable facilities

f. Cost report filed late with an unsatisfactory explanation

g. Many adjustments on previous reports; where the intermediary has reason to believe that similar problems exist on current reports

h. Frequency and types of audits performed by other auditors

i. Fraud or abuse investigation as directed by the HCFA regional office.

6. Critical or Sensitive Reimbursement Areas.—Particular attention should be given to those cost reports that frequently include appealed or protested issues to assure that cost report adjustments are properly handled. These issues might be of national impact or found only in certain regions; some of these issues might be major changes in reimbursement policies.

7. Validation Reviews.—The validation reviews done by the Office of Program Validation should be considered when developing the audit plan. The number of providers that have been or currently are under investigation are a factor indicative of where resources should be applied.

8. Cyclical Coverage.—Consideration should be given to those providers not selected through the above criteria. Selection will be made on a random basis of cost reports received as opposed to the length of time since an audit was last performed (e.g., every fifth cost report).

4104.3 Audit Selection.—After the professional preview has been completed, and taking into consideration the audit priorities, the intermediary will decide to:

1. Settle the cost report as filed

2. Perform a professional review to determine if field audit is necessary

3. Perform a field audit.

A. Cost Report Settlement Without Desk Review.—After the professional preview the reviewer might have sufficient documentation to settle the cost report with the proposed adjustments, if any, without any further work. Under this circumstance, the mathematical accuracy of the cost report will be verified if necessary. It is not necessary to perform mathematical verification of the cost report if electronically transferred or if every worksheet was computer prepared by means of a system listed in HCFA Pub. 13-2, section 2504ff. and submitted on hard copy. An assessment must be made of the reliability of hard copy computer-prepared cost reports, based on prior experience in determining the need for mathematical verification. If it is found that a computer-prepared cost report that HCFA has determined to be acceptable is not mathematically reliable, this information should be immediately reported to the Health Care Financing Administration, Attention: . Division of Institutional Services Reimbursement, BPP, Room 1-A-5 East Low Rise Building, 6325 Security Boulevard, Baltimore, Maryland 21207.

From these cost reports the intermediary will make random selections for professional review and audit. The frequency of the selection will depend on budgeted funds available in accordance with the audit work plan. This random selection will serve as a deterrent to those providers that otherwise do not routinely fall into the professional review or audit categories. In addition, it will form the basis for a self-assessment of the adequacy of the professional preview process and of the budgeted audit priorities.

B. Cost Reports for Professional Review.—Cost reports may also be selected through the professional preview for professional review. Professional review is necessary for cost reports where issues are identified through the professional preview but are not sufficiently developed at that point to make decisions on the cost report or the audit requirements, if any. The main purpose of the professional review is to establish whether an audit is necessary, and if so, set the scope of audit. Consequently, the complete desk review will be performed, that is, mathematical verification, if necessary, and professional review including comparative analysis.

C. Cost Reports to be Field Audited After Professional Preview.—The final alternative after the professional preview is to refer the cost report directly to field audit. This occurs when the reviewer establishes the need for audit and identifies audit issues through the professional preview process. Selected areas of the professional desk review may be performed after the professional preview to adequately scope the audit of individual issues. The budgetary audit priorities greatly influence this audit decision and the scoping process.

4104.4 Documentation of Selection Process.—Since the process for selecting cost reports for audit relies heavily on the reviewer's professional judgment, the basis for decision and the resulting decision must be documented. There are certain predetermined identifiable characteristics or circumstances of the provider's organization, operation or cost report set forth in the annual audit plan which serve as the basis for making decisions on desk review and/or the field audit that should be documented.

When the intermediary decides to defer audit, the decision must be consistent with the instructions for selecting cost reports and the budgeted audit priorities.

96

CHAPTER 3

GUIDELINES FOR BASE YEAR AUDITS UNDER THE MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES

	Section	Page
Background	4200	3-3/98
Target Amount Determination Process	4202	3-4/99
Audit Activity Planning	4202.1	3-4/99
Pre-Audit Review	4202.2	3-6/101
Performance of Hospital Audits	4202.3	3-14/132
Audit Performance Requirements	4202.4	3-15/133
Instructions to Home Office Intermediaries	4204	3-16/134
General	4204.1	3-16/134
Preparing for Chain Home Office Audits	4204.2	3-17/135
Audit Resolution and Transmittal to the Local Intermediaries	4204.3	3-19/137
Home Office Cost Determination for Nonconcurrent Reporting Periods	4204.4	3-19/137
Exhibits	4299	3-20/140

4200. BACKGROUND

The Medicare prospective payment system for inpatient hospital services is effective for cost reporting periods beginning on or after October 1, 1983. Details of the prospective payment system are described in the Provider Reimbursement Manual, Part I (HCFA-Pub. 15-1), Chapter 28. Prior to the implementation of the prospective payment system, fiscal intermediaries must determine target amounts for payment to hospitals. An essential portion of that work includes the determination of the correct inpatient operating cost for each hospital. These determinations must be made for each hospital prior to the hospital's first cost reporting period under the prospective payment system. The determinations are made using the following:

A. The hospital's base period cost report,

B. Supplementary information supplied by the hospital on Form HCFA-1008,

C. The audit of the base period cost report and supplementary information,

D. Other information available to the fiscal intermediary, and

E. Form HCFA-1007, (the worksheet for the target amount computation).

Fiscal intermediaries are required to establish as their highest priority the determination of target amounts for each hospital before each hospital comes under the prospective payment system. Under most circumstances (see HCFA Pub. 15-1, chapter 28 for exceptions), the following schedule is applicable to the target amount computation:

Base Period Ends	Base Period Cost Report Due	Supplementary Information on Form HCFA-1008 Due	Date Hospital Notified of Target Amount	Prospective Payment System Begins
09/30/82	12/31/82	6/15/83	8/15/83	10/1/83
10/31/82	01/31/83	6/15/83	09/1/83	11/1/83
11/30/82	02/28/83	07/15/83	10/1/83	12/1/83
12/31/82	03/31/83	07/31/83	11/1/83	01/1/84
01/31/83	04/30/83	07/31/83	12/1/83	02/1/84
02/28/83	05/31/83	07/31/83	01/1/84	03/1/84
03/31/83	06/30/83	07/31/83	02/1/84	04/1/84
04/30/83	07/31/83	08/31/83	03/1/84	05/1/84
05/31/83	08/31/83	08/31/83	04/1/84	06/1/84
06/30/83	09/30/83	09/30/83	05/1/84	07/1/84
07/31/83	10/31/83	10/31/83	06/1/84	08/1/84
08/31/83	11/30/83	11/30/83	07/1/84	09/1/84

Failure on the part of any fiscal intermediary to determine the target amount for each hospital subject to the prospective payment system and to notify the hospital of the determination by certified mail on or before the last date for such notification is unacceptable. The task of determining the target amount for each affected hospital and making timely notification to each hospital is an absolute requirement that takes precedence over any other duty, activity, or requirement of the fiscal intermediary's audit and reimbursement function.

Distribution of hospital fiscal year ending dates and number of hospitals serviced varies within and among intermediaries. Also, as indicated by the preceding chart, the amount of time to complete the process with respect to a hospital varies according to the beginning date of the hospital's first reporting period under the prospective payment system. Because of the unusual time restrictions, considerable flexibility is essential for successful management of fiscal intermediary processes and resources.

4202. TARGET AMOUNT DETERMINATION PROCESS

The following steps and considerations are common to the target rate setting process.

4202.1 Audit Activity Planning

A. Inventory Hospitals Serviced.—Fiscal intermediaries are to develop an inventory of hospitals serviced. The key elements in the development of this listing must include but are not limited to the following:

1. Identify which hospitals are subject to the prospective payment system, and which hospitals are exempt.

2. Identify the starting date under the prospective payment system for each hospital.

3. Identify which hospitals are members of chain operations.

4. Identify any factors which may adversely influence the intermediary's ability to audit.

B. Notification to Chain Home Office Intermediaries.—The local intermediaries are responsible for notifying the chain home office intermediaries of their needs for audited home office financial data. To provide for audit planning at the home office intermediary level, this notification should be made as soon as possible, even under the circumstances where a provider base period audit may be waived in accordance with §4202.1C. Notification to the home office intermediary should be made in the form of a Request for Audit under the terms of Prospective Payment for Inpatient Hospital Services and must include the following:

1. Provider name and number,

2. Provider base year cost reporting period,

3. The date the provider begins prospective reimbursement,

4. The date by which the audited home office data must be made available to the local intermediary (no later than 15 days prior to the provider notification date),

5. Identification of the different chain home offices affecting the base period where there has been a change of ownership,

6. The provider's Medicare utilization (percent of Medicare costs to total costs and the percent of Medicare discharges to total discharges), and

7. Chain home office cost and equity capital included in the Medicare cost report, if available.

If a provider's base period cost report is affected by multiple home office cost statements which are serviced by different intermediaries, each home office intermediary must be notified:

1. The chain consists of multiple offices with separate cost statements (e.g., home office and regional office reports).

2. Two separate chains have allocated costs into the base year cost report (e.g., where a sale of stock occurred during the period).

If the home office intermediary is unknown or not designated, contact the Health Care Financing Administration, Division of Operations, Bureau of Program Operations, Attention: Anne Sauer (301-594-6708), immediately to find out the identity of the home office intermediary.

C. Plan Hospital Audits

1. Intermediaries are to develop planning tools (which will include the Audit Priority Matrix) for prioritizing their providers for base period audits. To meet program objectives, intermediaries are no longer required to base the audit/no audit decision on existing policies and procedures. The objective is to audit all hospitals except where all of the following situations prevail:

a. There are no obvious indications that audit is necessary.

b. The hospital has been field audited for one of the three cost reporting periods before the base period.

c. The last audit of the provider resulted in no substantial adjustments (less than $1,000 in Medicare settlement).

d. The hospital had less than 10% utilization (i.e., Medicare patient days are less than 10% of total patient days).

e. The hospital had fewer than 100 Medicare discharges during the base period, and

f. Base year costs did not increase more than 10% over prior year cost.

2. Resource Management.—To insure all program objectives are met, intermediaries should:

a. Evaluate their current audit and reimbursement processes to determine if those processes can effectively achieve the objectives necessary for the establishment of the target rate under the prospective payment system.

b. Appraise personnel resources which will be needed to accomplish those objectives. Appraisals should include, but are not limited to the following:

(1) Professional staff.—Determine whether staff resources are adequate to handle planned audits and/or manage contracts.

(2) Clerical Staff.—Review needs during projected periods of high work concentration for overtime allocation and/or additional personnel.

(3) Subcontracts.—Review resources available under contract to assure that these resources will meet the fiscal intermediary needs to complete the base period reviews on a timely basis.

(4) Other Resources.—

a. Terminals for ADR Systems.—Determine whether terminals are sufficient to meet time constraints.

b. Space.—Determine whether space is available to house staff working on the prospective payment system.

c. Travel Funds.—Determine whether adequate travel funds have been allocated toward this effort.

c. Intermediaries should determine in their review of their provider inventory and resources, the total dollar impact and the time periods when those resources will be required.

d. Intermediaries are to prepare a work plan of their provider inventories and resources for accomplishing the audit. These plans are to be reviewed by the HCFA regional office for concurrence and audit funding.

4202.2 Pre-Audit Review - General.—The normal requirements for pre-audit activity (as specified in §4100ff and §4104ff) are suspended for the duration of the period of high intensity review necessary to generate the target amount for each hospital subject to the prospective payment systems. In place of those requirements, the pre-audit activities described in this section may be used for the purpose of developing the scope of work necessary to determine each hospital's target amount during the review of the base period cost reports. If the intermediaries believe that their pre-audit review will more accurately develop the scope of audit specified in the standards for the development of the audit scope portion of this section, then they may substitute their review in place of the one described herein.

The pre-audit review is a preliminary analysis of the cost report and the provider's background to determine the extent of field audit necessary. It is intended to create and document an immediate awareness for (1) changes in provider's operations (2) issues open from prior reviews, (3) referrals from previous audits, and (4) potential base year adjustment items requiring verification. The reviewer will have available for the pre-audit review the following items:

a. Cost Report
b. Questionnaire on Changes in Provider's Operations
c. Automated Desk Review
d. Provider Permanent Reference File
e. Working Trial Balance
f. Financial Statements (where available)
g. Prior Years Audit Notes and Audit Adjustments
h. Current Appeal Issues (provider's and national issues)
i. Form HCFA-1008

A. Pre-Audit Activity.—The following steps are recommended for the performance of the pre-audit review:

1. Evaluation of Questionnaire on Changes in Provider's Operation.—Questionnaires on changes in provider's operations are presently used to update the permanent reference file. (Presently, fiscal intermediaries use a variety of questionnaires of their own design which have been approved for use by the Office of Management and Budget. The questionnaires should be used until HCFA issues a standard questionnaire.)

Whenever a change does occur, the provider submits a copy of the appropriate supporting documentation according to the submission requirements established with the intermediary. In this way, the intermediary is alerted to changes occurring at the provider which impact reimbursement. The professional reviewer will use the questionnaire to become more familiar with the provider's operation and general profile and to more effectively identify problem areas and determine the direction of the field audit.

(NOTE: During this period of high intensity audit, the requirement for the updating of the permanent reference file will be relaxed. The permanent reference files will be updated after the rates are determined (in final) for the prospective payment system.)

2. Evaluation of Comparative Analysis Data.—Review the comparative analysis generated by the Automated Desk Review. The purpose of performing a comparative analysis is to determine those cost report items that appear to warrant further consideration. Variances could exist as dollar variances, statistical variances, and per diem or per visit variances. A comparative analysis is made between the current and

prior reporting periods. Variances in excess of a predetermined percentage and/or amount of increase or decrease (tolerance) will be the criteria for noting exceptions. Also, the materiality of the variance will be a determining factor as to whether the variance warrants additional audit effort.

Intermediary decisions as to the materiality of a particular variance will be accepted and supported by HCFA if:

a. The definition of materiality is clearly established by the intermediary, is documented, and is communicated to all staff,

b. The materiality concept as applied is reasonable under the existing circumstances, and

c. That concept of materiality is applied consistently.

If the variance of a particular cost item exceeds the established tolerance, but the intermediary determines that the variance is immaterial, the determination should be explained in the workpapers.

The following types of comparative analyses may be helpful in the scoping of the audit:

a. Comparative Analysis of Patient Service Cost.—These comparisons are on costs giving effect to utilization (e.g., worksheet C gives effect to cost to charge comparisons). These are made in order to determine those cost centers that incurred significant variances between current and prior years and warrant further professional review. The reference table shown below should be followed when making the comparative analysis:

FORM HCFA-2552-81

Worksheet	Column	Line
C	2	All
C	8	30a
C	10	30a
D (Hospital)	7	28
D (Hospital)	8	28
D-1 Part 1	1	19
D-1 Part 1	2	19
D-1 Part 1	3	19
D-1 Part 1	4	19
D-1 Part 1	1	32
D-1 Part 1	2	32
D-1 Part 1	3	32
D-1 Part 1	4	32
D-1 Part 1	1	34
D-1 Part 1	2	34
D-1 Part 1	3	34
D-1 Part 1	4	34

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Health Care Program Inpatient Expenses Title XVIII - Part A							
Oxygen (Inhalation) Therapy		X	D		13	7	
Physical Therapy		X	D		14	7	
COMPUTATION OF INPATIENT ROUTINE SERVICE COST - WORKSHEET D-1							
Worksheet D-1—All non-calculated items necessary for reimbursement			D-1				
Total inpatient routine nursing salary cost (Excluding nursery)							
Hospital			D-1	I	9	1	
All Subproviders (Specify all)			D-1	I	9	2 or 3	
SNF-Certified			D-1	I	9	4	

---

[5] Specify only the detail that applies to a particular cost center.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Total inpatient routine service cost (Excluding inpatient routine nursing salary cost)							
Hospital		X	D-1	I	10	1	
All Subproviders (Specify all)		X	D-1	I	10	2 or 3	
SNF-Certified		X	D-1	I	10	4	
Total Medicare general inpatient routine service cost before reasonable cost limitation							
Hospital		X	D-1	I	22	1	
All Subproviders (Specify all)		X	D-1	I	22	2 or 3	
SNF-Certified		X	D-1	I	22	4	
Aggregate charges to beneficiaries for excess costs							
Hospital			D-1	I	23	1	
Depreciation allocated to general inpatient routine service							
Hospital		X	D-1	I	29	1	
All Subproviders (Specify all)		X	D-1	I	29	2 or 3	
SNF-Certified		X	D-1	I	29	4	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
General inpatient routine service cost limitation							
Hospital		X	D-1	I	35	1	
All Subproviders (Specify all)		X	D-1	I	35	2 or 3	
SNF-Certified		X	D-1	I	35	4	
Reimbursable general inpatient routine service cost							
Hospital		X	D-1	I	38	1	
APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS - WORKSHEET D-2							
Worksheet D-2—All non-calculated items necessary for reimbursement			D-2				
APPORTIONMENT OF PROVIDER-BASED PHYSICIAN REMUNERATION FOR PROFESSIONAL SERVICE - WORKSHEET D-3							
Worksheet D-3—All non-calculated items necessary for reimbursement			D-3				

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
APPORTIONMENT OF MALPRACTICE INSURANCE COSTS - WORKSHEET D-8							
Worksheet D-8—All non-calculated items necessary for reimbursement			D-8				
CALCULATION OF REIMBURSEMENT SETTLEMENT - TITLE XVIII - WORKSHEET E							
Worksheet E—All non-calculated items necessary for reimbursement			E				
Part I							
Inpatient ancillary services							
Hospital - Part A		X	E	I	1	1	
Hospital - Part B 80%		X	E	I	1	3	
Outpatient services							
Hospital - Part B 100%		X	E	I	2	2	
Malpractice Insurance Costs							
Hospital - Part A		X	E	I	10	1	
Hospital - Part B 100%		X	E	I	10	2	
Hospital - Part B 80%		X	E	I	10	3	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Subtotal (E, Part I, line 12)							
Hospital - Part A		X	E	I	12	1	
Part II							
Allowable return on equity capital							
Hospital - Part A		X	E	II	25	1	
Hospital - Part B 100%		X	E	II	25	2	
Hospital - Part B 80%		X	E	II	25	3	
Total kidney acquisition charges billed to Medicare under Part B							
Hospital			E	II	36	1	
Total charges for Title XVIII Part A and Part B services							
Hospital - Part A		X	E	II	38	1	
Hospital - Part B 100%		X	E	II	38	2	
Hospital - Part B 80%		X	E	II	38	3	
All Subproviders - Part A (Specify all)		X	E	II	38		
All Subproviders - Part B (Specify all)		X	E	II	38		
SNF-Certified - Part A		X	E	II	38	8	
SNF-Certified - Part B		X	E	II	38	9	

108

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Excess of Aggregate Costs Over Aggregate Charges							
Hospital		X	E	II	45	1	
Part III							
Total Cost - current cost reporting period							
Hospital - Part A		X	E	III	61	1	
Hospital - Part B 100%		X	E	III	61	2	
Hospital - Part B 80%		X	E	III	61	3	
Recovery of Unreimbursed Costs Under Lesser of Cost or Charges							
Hospital - Part A		X	E	III	63	1	
Hospital - Part B 80%		X	E	III	63	3	
Total Cost - reimbursable to provider							
Hospital - Part A		X	E	III	69	1	
Hospital - Part B 100%		X	E	III	69	2	
Hospital - Part B 80%		X	E	III	69	3	
All Subproviders - Part A (Specify all)		X	E	III	69		
All Subproviders - Part B (Specify all)		X	E	III	69		
SNF-Certified - Part A		X	E	III	69	8	
SNF-Certified - Part B		X	E	III	69	9	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED TO TITLE XVIII (MEDICARE) BENEFICIARIES - WORKSHEET E-1							
Entire worksheet (including dates)							
Hospital			E-1				
All Subproviders (Specify all)			E-1				
SNF-Certified			E-1				
CALCULATION OF REIMBURSEMENT SETTLEMENT - WORKSHEET E-5							
Worksheet E-5—All non-calculated items necessary for reimbursement			E-5				
BALANCE SHEET - WORKSHEET G							
Total Current Assets-General Fund [6]	X	X	G		11	2	
Total Fixed Assets-General Fund [6]	X	X	G		27	2	
Total Other Assets-General Fund [6]	X	X	G		32	2	

---

[6] The locations noted apply only when the data are reported on Worksheet G or G-3; however, these data items should be reported if not on Worksheet G or G-3 as discussed in Section 4023.2.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Total Assets - General Fund 6/	X	X	G		33	2	
Total Current Liabilities - General Fund 6/	X	X	G		42	7	
Total Long-Term Liabilities - General Fund 6/	X	X	G		49	7	
Total Fund Balance - General Fund 6/	X	X	G		58	7	
Total Liabilities and Fund Balance - General Fund 6/	X	X	G		59	7	
STATEMENT OF REVENUE AND EXPENSES - WORKSHEET G-3							
Total Patient Revenues 6/	X	X	G-3		1		
Allowances and Discounts on Patients' Accounts 6/	X		G-3		2		
Total Operating Expenses 6/	X	X	G-3		4		

---

[6] The locations noted apply only when the data are reported on Worksheet G or G-3; however, these data items should be reported if not on Worksheet G or G-3 as discussed in Section 4023.2.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
Total Other Income [6]	X	X	G-3		26		
Total Other Expenses [6]	X	X	G-3		31		
Net Income (or Loss) for Period [6]	X	X	G-3		32		Equal to Total Patient Revenues less Allowances and Discounts on Patients Accounts, less Total Operating Expenses, plus Total Other Income, less Total Other Expenses
APPORTIONMENT OF REMUNERATION APPLICABLE TO HOSPITAL-BASED PATHOLOGISTS - SUPPLEMENTAL WORKSHEET D-4							
Worksheet D-4—All non-calculated items necessary for reimbursement			D-4				
COST APPORTIONMENT OF AMBULANCE SERVICES RENDERED BY PROVIDER - SUPPLEMENTAL WORKSHEET D-5							
Worksheet D-5—All non-calculated items necessary for reimbursement			D-5				

---

[6] The locations noted apply only when the data are reported on Worksheet G or G-3; however, these data items should be reported if not on Worksheet G or G-3 as discussed in Section 4023.2.

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
COMPUTATION OF KIDNEY ACQUISITION COSTS AND CHARGES - SUPPLEMENTAL WORKSHEET D-6							
Worksheet D-6—All non-calculated items necessary for reimbursement			D-6				
ADJUSTMENT TO RENAL DIALYSIS COST CENTER FOR PROVIDERS - SUPPLEMENTAL WORKSHEET D-7							
Worksheet D-7—All non-calculated items necessary for reimbursement			D-7				
APPLICATION OF THE LIMITATION ON OUTPATIENT RENAL DIALYSIS COSTS - SUPPLEMENTAL WORKSHEET E-3							
Worksheet E-3—All non-calculated items necessary for reimbursement			E-3				

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
RECOVERY OF UNREIMBURSED COSTS - SUPPLEMENTAL WORKSHEET E-4							
Worksheet E-4 - All non-calculated items necessary for reimbursement			E-4				
RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS - SUPPLEMENTAL WORKSHEET F							
Worksheet F—All non-calculated items necessary for reimbursement			F				
Total Fixed Assets Balance Sheet per Books		X	F	I	26	2	
Total Liabilities Balance Sheet per Books		X	F	I	50	6	
Home office (or other related organization) equity capital end of period (for prior period and all current periods)			F	II	1-14	9	

Table 2: Medicare Cost Report Data Specifications

Data Element Name	Nonreimbursement Item	Calculation	Worksheet	Part	Line	Column	Edit to be Applied
REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS - SUPPLEMENTAL WORKSHEET A-8-3							
Worksheet A-8-3—All non-calculated items necessary for reimbursement			A-8-3				
APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS - SUPPLEMENTAL WORKSHEET D-9							
Worksheet D-9 - All non-calculated items necessary for reimbursement of hospital and subprovider(s)			D-9				
CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B - SUPPLEMENTAL WORKSHEET I-3							
Reimbursable Bad Debts		X	I-3		9	1	

TABLE 3: VALUES FOR SPECIAL CODES

Field	Legal Values
Status of Cost Report	1 = As submitted after mathematical checks 2 = Settled without audit 3 = Settled with audit 4 = Reopened
Version of Cost Report	1 = 11/81
All Inclusive Rate Method	A,B,E, or N (for No)
Type of Cost Allocation Method Used	1 = Stepdown 2 = Double Apportionment - Accumulative 3 = Double Apportionment - Nonaccumulative 4 = Matrix or Simultaneous Equation 5 = Other - Specify
ADR Vendor	1 = Coopers & Lybrand 2 = Ernst & Whinney 3 = John F. Forbes & Co. 4 = Laventhol & Horwath 5 = Blue Cross, Blue Shield of Greater New York 6 = Peat, Marwick, Mitchell & Co.
Type of Control	Voluntary Nonprofit 1 = Church 2 = Other Proprietary 3 = Individual 4 = Corporation 5 = Partnership 6 = Other Government 7 = Federal 8 = City-County 9 = County 10 = State 11 = Hospital District 12 = City 13 = Other

TABLE 3: VALUES FOR SPECIAL CODES

Field	Legal Values
Type of Hospital	1 = General - Short Term 2 = General - Long Term 3 = Tuberculosis 4 = Specialty-Short Term 5 = Specialty-Long Term 6 = Chronic Disease 7 = Psychiatric 8 = Other
Type of Physician Reimbursement Method Renal Dialysis	1 = Initial 2 = Alternative
All Yes/No questions	Y or N
All dates	MM/DD/YY format

4024. SPECIFIC WORKSHEET INSTRUCTIONS AND EXAMPLES

This section augments the standard format description in Section 4021.4.2 with specific worksheet instructions and examples of the standard format.

4024.1 General Instructions for Determining Lines and Columns.—To determine lines and columns, use the preprinted line numbers and column numbers on the worksheets. Where line numbers and column numbers are not preprinted, use the following general rules. Specific worksheet by worksheet instructions follow.

1. When a Part of a Worksheet has only one column in the entire part, this column is treated as column 1. For example, Worksheet A-3 has only one column; this column is treated as column 1. Another example is Statistical Data, Part III; the one column is treated as column 1.

2. When a Part of a Worksheet has several numbered columns, and then decreases to fewer columns which are not numbered, treat the columns as being numbered the way the columns directly above them are numbered. For example, on Worksheet D-6, Part I, there are three columns on lines 1a, 1b, 1c, 1d, and 1e. The single column on line 1f is treated as column 3, the column immediately above it.

Note: When the Worksheet Part changes, this no longer applies. General rule 1 is used instead. On Worksheet D-6, Part II, the single column is column 1.

3. When a line is preprinted as a number and has several lines below it labeled alphabetically, combine the number with the letters of the alphabet to report each line. For example, in the Statistical Data, Part II, line 10, is followed by lines labeled a, b, c, etc. Each line under line 10 is reported as 10A, 10B, 10C, etc.

4. When a column overlaps the boundaries of the preprinted columns, use the column number of the first column directly above it. For example, in Worksheet E, Part II, line 40, the Hospital column is column 1, the Subprovider I column is column 4, etc.

5. When data can be indicated within the label for a line (e.g., the Period End dates for Worksheet E-4, Part III), indicate the column number as zero for this item. If more than one such value can be inserted in the label for a line (e.g., Per Diem Limitation on Worksheet D-1, line 35), indicate the column number as zero and use sub-column numbers of 1 and 2.

4024.2 Statistical Data - Part I.

Item 1. Names and Addresses, Provider Numbers, and Dates Certified.

Each of the components is indicated as line 1 with a separate sub-line, (i.e., hospital is sub-line 1; Subprovider I is sub-line 2; Subprovider

118

II is sub-line 3; and SNF is sub-line 4). The Name is indicated as column 1, the Provider Number is column 2, and the Date Certified is column 3. The Address field should not be reported.

For example, General Hospital, Provider Number 00-0001, was certified 12/7/67. It has a SNF, General SNF, Provider Number 00-0002, which was certified 12/7/68. This information is reported as follows:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3S000001    1 1  1  GENERAL HOSPITAL
3S000001    1 1  2           000001
3S000001    1 1  3  12/07/67
3S000001    1 4  1  GENERAL SNF
3S000001    1 4  2           000002
3S000001    1 4  3  12/07/68
```

Item 2. Cost Reporting Period.

The beginning date of the cost report is treated as line 2, column 1; the end date as line 2, column 2.

Item 3. Type of Control.

The Type of Control is treated as line 3, column 1. The values are defined in Section 4023.6, Table 3.

For example, Type of Control is Proprietary - Corporation (Code 4). This is reported as follows:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3S000001    3    1                 4
```

Item 4. Type of Hospital.

The type of hospital is treated as line 4, column 1. The values are defined in Section 4023.6, Table 3.

4024.3. Statistical Data - Part II.--This part follows all general rules.

4024.4. Statistical Data - Part III.--This part follows all general rules. The column is numbered 1.

4024.5. Statistical Data - Part IV.--This part follows all general rules.

4024.6. Statistical Data - Part V.--This part follows all general rules. The columns are numbered 1, 2, and 3 respectively.

4024.7. Statistical Data - Part VI.

Lines 1i and 1j

The Census Count and Home Health Aide Hours--Title XVIII are column 1; the Count and Hours--Other are column 3; and the Count and Hours--Total are column 5.

Line 2

The Number of Hours in a Normal Work Week should be indicated as line 2 column 0. The other lines are indicated as line 2A, 2B, etc.

For example, if there are 40 hours in a normal work week, this is reported as follows:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3S000006    2    0                40
```

4024.8. Statistical Data - Part VII.

Line 1

The Type of Reimbursement Method is indicated as line 1, column 1. The value is as defined in Section 4023.6, Table 3.

If the Alternative Method is used, the Date for Election for the Alternative Method is indicated as line 1, column 2.

Line 1h

The Machine Time Used in a Typical Week Per Shift must be indicated for each shift operated. The first shift is indicated as line 1h, sub-line 1; the second shift as line 1h, sub-line 2, and the third shift as line 1h, sub-line 3.

For example, the average machine time for the outpatient hemodialysis is 300 hours in the first shift and 350 in the second shift. These data are reported as follows:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3S000007   1H 1  1               300
3S000007   1H 2  1               350
```

Lines 1i and 1l

Each Type of Dialyzer is indicated as Y=Yes or N=No on line 1i; sub-line 1, 2, 3, or 4 (as printed on the cost report); column 1. The Number of Times Reused is indicated as column 2; for Other, sub-line 4, type is indicated as column 3. Where a type is not used, the answer No need not be provided.

For example, on line 1i, if parallel plate dialyzers are used and coil dialyzers are reused twice, their data are reported as follows:

```
             1    1    2    2    3    3    4    4    5    5    6
    1...5....0....5....0....5....0....5....0....5....0....5....0

    3S000007 1I 2  1  Y
    3S000007 1I 3  1  Y
    3S000007 1I 3  2                 2
```

Line 2

The Number of Hours in a Normal Work Week is indicated as line 2 column 0.

4024.9. Worksheet A.--This worksheet follows all general rules. Cost center labels are indicated as described in Section 4021.4.3.

4024.10. Worksheet A-1.--This worksheet follows all general rules.

4024.11. Worksheet A-2.--This worksheet follows all general rules. In Part II, the column number is 1.

4024.12. Worksheet A-3.--This worksheet follows all general rules. The column number is 1.

4024.13. Worksheet A-4.--This worksheet follows all general rules. The column number is 1.

4024.14. Worksheet A-5.--This worksheet follows all general rules. The column number is 1.

4024.15. Worksheet A-6.--This worksheet follows all general rules. The Explanation of Reclassification entry is treated as a line label and indicated as column 0. Columns 2 and 5 need not be reported.

4024.16. Worksheet A-7.

Line 1

All data for Land are reported as line 1, sub-line 1; Land Improvements as line 1, sub-line 2; Buildings & Fixtures as line 1, sub-line 3; etc.

Lines 3 and 4

Data should be indicated as line 3A, 3B, etc.; 4A, 4B, etc.

4024.17. Worksheet A-8.—This worksheet follows the general rules. Description of adjustments are indicated as column 0. Column 3 need not be reported.

4024.18. Worksheet A-8-1.—In Part A, the line number should be indicated as 1, the column as 1. In Part B, column 2 need not be reported.

4024.19. Worksheet A-8-2.

Line 1

Each depreciation amount is indicated as line 1A, 1B, 1C, and 1D as indicated.

Line 2

Where appropriate, the Balance in Fund At End of Period is reported as line 2, column 0. In column 1, a "Y" or "N" is indicated for Yes or No.

Line 3

Indicate a "Y" or "N" in line 3, column 1.

Line 4

Indicate "Y" or "N" in lines 4, 4A, 4B, and 4C, column 1, as appropriate.

4024.20. Worksheet B.—This worksheet follows the general rules. Cost center labels are not necessary since they are reported for Worksheet A.

4024.21. Worksheet B-1.—This worksheet follows the general rules. Cost center labels are not necessary since they are reported for Worksheet A. Nonstandard bases are reported as indicated in Section 4021.4.3.

4024.22. Worksheet C.—This worksheet follows the general rules. Lines are indicated as 2B, 3B, 4B, etc. Cost center labels are not necessary since they are reported for Worksheet A.

4024.23. Worksheet D.—This worksheet follows the general rules.

4024.24. Worksheet D-1.

Line 25

Directly Assigned Capital Related Costs are indicated as lines 25.4, 25.5, ... 25.AA, 25.AB, column 0. Where necessary, sub-lines are indicated as on Worksheet A.

Line 35

The Per Diem Limitations reported in the line label are indicated as line 35, column 0, sub-column 1 and 2 respectively.

For example, a provider has a per diem limitation of $75 for the hospital and $50 for the SNF. These data are reported as follows:

```
         1    1    2    2    3    3    4    4    5    5    6
1...5....0....5....0....5....0....5....0....5....0....5....0

3D100001   35 0    1              75
3D100001   35 0    2              50
```

Line 60

The Per Diem Limitation reported in the line label is indicated as line 60, column 0.

4024.25. Worksheet D-2.--This worksheet follows the general rules. Note that columns for Part I lines 16 through 19 are column 1, 2, A, B, C, D, E, F, G, 9, and 10 as preprinted on the worksheet.

4024.26. Worksheet D-3.--This worksheet follows the general rules.

4024.27. Worksheet D-8.

Lines 2 through 5

The years entered in the line labels are indicated as line 2, 3, 4, or 5 and column 0.

Line 7

The national ratios are entered as lines 7A, 7B, 7C, column 1.

Lines 8 through 16

The column for lines 8 through 16 is column 1.

4024.28. Worksheet E.--When a column overlaps the boundaries of the preprinted columns, use the column number of the first column directly above it, e.g., in Part II line 40, the hospital column is 1, the Subprovider I column is 4, the Subprovider II column is 6, and the SNF column is 8.

4024.29. Worksheet E-1.--For Worksheet E-1, for Category 1, Inpatient Part A, indicate the date in column 1, the amount in column 2; for Category 2, Inpatient Part B, indicate the date in column 3, the amount in column 4; for Category 3, Outpatient Part B-100 percent, indicate the date in column 5, the amount in column 6; and for Category 4, Outpatient Part B-80 percent, indicate the date in column 7, the amount in column 8.

4024.30. Worksheet E-5.--This worksheet follows the general rules.

4024.31. Worksheet G.—This worksheet need only be reported to the extent described in Section 4023.2.

The Assets label column is column 0; the Assets General Fund is column 1; the Assets Specific Purpose Fund is column 2; the Assets Endowment Fund is column 3; the Assets Plant Fund is column 4; the Liabilities label column is column 0; the Liabilities General Fund is column 1; the Liabilities Specific Purpose Fund is column 2; the Liabilities Endowment Fund is column 3; and the Liabilities Plant Fund is column 4.

4024.32. Worksheet G-1.—This worksheet need not be reported. If reported, the line labels are indicated as column 0. The General Fund is column 1; the Specific Purpose Fund is column 2; the Endowment Fund is column 3; and the Plant Fund is column 4.

4024.33. Worksheet G-2.—This worksheet need not be reported. If reported, for Part II, the line labels as column 0, and the data as column 1.

4024.34. Worksheet G-3.—This worksheet need only be reported to the extent described in Section 4023.2. Indicate line labels where necessary as column 0; data values as column 1.

4024.35. Supplemental Worksheet D-4.—This worksheet follows the general rules. Indicate the column as 1.

4024.36. Supplemental Worksheet D-5.—This worksheet follows the general rules. Indicate the column for lines 1, 2, and 3 as column 1.

4024.37. Supplemental Worksheet D-6.—This worksheet follows the general rules. For Part I, indicate the column for lines 1F, 2D, 3, 4, 5, 6, and 7 as column 3. For Part II, the column is 1.

4024.38. Supplemental Worksheet D-7.—This worksheet follows the general rules. The column for Part III is column 1.

4024.39. Supplemental Worksheet E-3.—This worksheet follows the general rules.

4024.40. Supplemental Worksheet E-4.—This worksheet follows the general rules. In Part III, lines are indicated as 1A, 1B, etc. The dates in the line labels are indicated as column 0 as described in General Rule 5 in Section 4024.1.

4024.41. Supplemental Worksheet F.—This worksheet follows the general rules. In Part I, the column for lines 54 through 60 is column 8.

Part II, Line 16

For line 16, the non-calculated item is Annual Rate of Return. This should be indicated as line 16, column 4.

Part III, Lines 1, 2, and 3

The column for Part III lines 1, 2, and 3 is column 1.

4024.42. Supplemental Worksheet A-8-3.--For all parts the unlabeled column is column 1.

Lines 5, 6, 7, 9, and 10

All dates are indicated as column 0 of the line printed immediately following the Period. For example, on line 5, to indicate the first Period, use line 5A, column 0, start date in sub-column 1 and end date in sub-column 2. The second Period is reported as line 5C, column 0, sub-columns 1 and 2.

Line 11

Indicate the Period printed immediately preceding line 11 as line 11, column 0, start date in sub-column 1, and end date in sub-column 2.

Line 23

Indicate the Period printed immediately preceding line 23 as line 23, column 0, start date in sub-column 1, and end date in sub-column 2.

4024.43. Supplemental Worksheet D-9.—This worksheet follows general rules.

4024.44. Supplemental Worksheet H Series.—These worksheets are not required.

4024.45. Supplement Worksheet I Series.—Worksheet I-3, line 9, column 1 is requested. The remainder of the worksheets are not required.

CHAPTER 2
GUIDELINES FOR PERFORMING PROVIDER AUDITS

	Section	Page
Audit - General	4100	2-3 /90
Intermediary's Responsibilities	4100.1	2-3 /90
Definitions	4100.2	2-3 /90
Audit Work Plan and Selection Process	4104	2-5 /92
Professional Preview	4104.1	2-5 /92
Audit Priority Considerations	4104.2	2-7 /94
Audit Selection	4104.3	2-8 /95
Documentation of Selection Process	4104.4	2-9 /96

D-1 Part 1	3	39
D-1 Part 1	3	40
D-1 Part 1	3	41
D-1 Part 1	3	42

b. Comparative Analysis of Cost Allocation.—A comparative analysis is made of cost allocation to determine that reasonable consistency with the prior period exists. This is accomplished through performing the three basic steps below:

1. Sequence of Allocation.—The sequence of allocation for the current period is compared to that of the prior period. Any deviation from the sequence provided for on the official HCFA form or any change in sequence occurring in the current period should be referred for further review to consider items such as whether prior approval was obtained from the intermediary for allowing a sequence change. If the sequence changes in the current period, then the actual cost allocation of the cost report item affected is compared to determine the effect(s) of such change. If the allocation sequence is consistent with the prior period, then the review will proceed to the next function. The following reference table is followed when making the comparative analysis of the allocation sequence:

FORM HCFA-2552-81

Worksheet	Column	Line
B	Cost Center	1-20

2. Allocation Basis.—The basis of allocation for the current period is compared to those of the prior period for consistency. Any changes to allocation basis should be referred for further review to consider items such as prior approval from the intermediary to allow the change. If an allocation basis changes in the current period, then the actual cost allocation of the cost report item affected is compared to determine the effect(s) of such change. If the allocation bases are consistent with the prior period, then the review will proceed to the next function. The following reference table is followed when making comparative analysis of allocation bases:

FORM HCFA-2552-81

Worksheet	Column	Line
B-1	2-20	"headings"

3. Allocation Statistics.—The statistics used to allocate costs for the current period are compared to those of the prior period for consistency. The following reference table is followed when making comparative analysis of allocation statistics:

FORM HCFA-2552-81

Worksheet	Column	Line
B-1	2-20	2-78

c. Comparative Analysis of Whole Dollars.—A comparative analysis is made of costs prior to allocation on whole dollar amounts. The purpose for these comparisons is to isolate possible causes for significant variances noted from the analysis of patient service cost and cost allocation; and to determine if there are significant offsetting variances that had no net effect on the prior analyses but warrant further review. The reference table shown below is used to make the comparative analysis of whole dollars:

FORM HCFA-2552-81

Worksheet	Column	Line
A	1	All
A	2	All
A-1	1	All
A-1	2	All
A-1	3	All
A-1	4	All
A-1	5	All
A-1	6	All
A-2	2	All
A-2	3	All
A-2	4	All
A-2	5	All
A-3	1	All
A-4	1	All
A-5	1	All
A-6	2-7	All
A-7	1	All
A-7	2	All
A-7	3	All
A-7	5	All
A-8	2	All
A-8-2	1	A-D
A-8-3 Part I	1	All
A-8-3 Part II	1	All
A-8-3 Part II	2	All

d. Comparative Analysis of Utilization Statistics.—A comparative analysis is made of utilization statistics. The results of this analysis is considered together with the results of all previous analyses to assist in making the determination whether significant variances noted are the result of changes in utilization or other factors that warrant examination. Therefore, the instruction for the computation of

128

tolerances (§4202.2A2e) do not apply. Conversely, this analysis may invalidate the results of other analyses that noted no exceptions. For example, comparison of the cost to charge ratio in §4202.2A2a may have resulted in no exceptions, indicating that cost and utilization changed proportionately from one period to the next. Comparisons of utilization statistics may indicate that the presumption is incorrect and that charges were not increased proportionately with costs. Consequently, this information will assist the professional reviewer in determining the validity of the results implied by other comparative analyses. The following reference table is followed when making the comparative analysis:

FORM HCFA-2552-81

Worksheet	Column	Line
Page 3, Part II	All	6
Page 3, Part II	All	7
Page 3, Part III	All	10i
Page 3, Part III	All	4a
Page 3, Part III	All	4c
Page 3, Part III	All	7a
Page 3, Part III	All	7c
Page 4, Part IV	All	6
Page 4, Part IV	All	7
Page 4, Part V	All	6e
Page 4, Part V	All	6c

e. Instructions for Computing Tolerances.—These instructions are guidelines for reviewing variances which exceed a predetermined percentage or amount of increase or decrease (tolerance). To determine an acceptable tolerance level, the person performing the pre-audit review should perform the following steps.

(NOTE: This section is to only be used for the computation of tolerance levels related to cost.)

Obtain the consumer price index (CPI Detailed Report published by the U.S. Department of Labor; it can be obtained from your local public library or from the U.S. Department of Labor) for medical care services as of the end of the provider's prior and current reporting periods. Compute the CPI from tables 16 or 17 listing the metropolitan area where the provider is located (for those providers not listed in one of the areas indicated on tables 16 or 17, refer to table 25 for the appropriate CPI index). Add 1 percentage point to the CPI computed increase/decrease to obtain the variance tolerance.

EXAMPLE: XYZ Hospital, located in Cleveland, Ohio, medical care services tolerance for cost reporting period ending December 31, 1981, is 11.8% plus 1% gives a variance tolerance of 12.8%.

INDEX POINT CHANGE

CPI 12/81	356.3
Less prior index 12/80	318.8
Equals index point change:	37.5

PERCENT CHANGE

Index point difference	37.5
Divided by the prior index	318.8
Equals:	0.118
Results multiplied by one hundred	0.118 x 100
Equals percent change:	11.8

VARIANCE TOLERANCE

Percent change	11.8
Plus 1 percent	1.0
Equals Variance Tolerance	12.8

Variances exceeding this tolerance are to be reviewed subject to the intermediary's definition of materiality (§4202.2A2).

3. Evaluation of the Working Trial Balance.—The Provider Reimbursement Manual, Part 2 (HCFA-Pub. 15-2), §306, requires all providers filing cost reports on HCFA-2552 to submit a copy of the working trial balance (WTB) which links the cost report with the provider's accounting records and financial statements. The Pre-Audit Review of the WTB includes, but is not limited to the following review steps:

a. Reconciliation of the total expenses shown on the working trial balance to the total expenses claimed on the provider's cost report.

b. Review of new accounts to determine their allowability for program purposes.

c. Review of account classifications to assure consistency with prior years. (If prior year's WTB is available.)

d. Review of miscellaneous income to determine if necessary offsets were made and to determine the consistency of those adjustments with the prior years.

e. Review of non-reimbursable accounts to determine if they were properly reflected on the cost report.

f. If available, the effect of adjustments proposed by the provider's accountant.

4. Evaluation of Financial Statements.—Where financial statements are available, they may serve as a direct source for identifying problem areas in the current cost report. This review process is a search for compliance in applying the principles of reimbursement. The review of the provider's financial statements includes, but is not limited to, the following:

a. Review the notes to the financial statements for any unusual items or changes in accounting policy (an example of this could be a change in the provider's capitalization policies or change in method of valuing inventories).

b. Review the auditor's opinion to determine if there were any qualifications which would have an impact on reimbursement.

c. Reconcile the total expenses shown on the financial statements with the total costs claimed on the cost report.

d. Review other income (if separately identified) to determine if necessary offsets were made to the cost report and to determine the consistency of those adjustments with prior years.

e. Review liabilities to determine if proper adjustments for capital related interest have been made.

5. Evaluation of Prior Years' Referrals and Audit Adjustments.—The professional reviewer will consider prior year's audit referrals and prior year's audit adjustments for possible applicability to the current cost report. The purpose is to review the prior year's audit notes and adjustments for awareness and to decide if these are applicable to the current year cost report, if they are identifiable in the cost report and if they are properly reflected there.

6. Evaluation of Appeal Issues.—The appeal issues to be considered are both those in which the provider is currently involved and national and/or group appeal issues in which the provider is not currently a party but which could possibly apply. The reviewer will decide after reviewing the current cost report and current correspondence files if the appealed cost items are correctly treated.

7. Special Audit Issues.—The special issues listed in §4202.2B5 are to be reviewed in order to determine whether field audit is necessary. Where the intermediary determines that no further review is necessary, the decision is to be documented and further review may be waived. Where the results of the intermediary review indicates that further effort is necessary, then the intermediary is to refer the issue to field audit. The intermediary is to insure that in all cases the procedures enumerated in §4202.3B, 1 through 4 must be performed.

B. Standards for the Development of the Audit Scope.—After considering all of the foregoing and properly documenting the analyses through brief notations that these areas have been reviewed and preparing a list of potential exceptions, identify the potential audit issues and set the scope of audit. In setting the audit scope, ensure that:

1. The audits have scope and depth that are commensurate with the additional audit resources made available by HCFA.

2. The scope and depth are set to obtain maximum effectiveness in use of audit resources, taking into consideration that the results of the audit will be used for three purposes stated in § 4202.3A.

3. Reimbursement issues of special interest with respect to the individual provider are considered in the scope of audit.

4. The appeal issues reflected in prior reviews of the provider and/or identified in the base period cost report are sufficiently considered in the scope of audit.

5. The special issues which could influence the base period rate are properly covered with respect to the provider. Further discussion of the issues listed below appear as exhibits later in this chapter.

a. Capital Related Costs
b. Medical Education
c. FICA Tax
d. Provider Based Physicians
e. Non-Physician Services Billed Under Part B (Unbundling)
f. Medicare Discharges
g. Prepaid Expenses
h. Inventories
i. Accruals
j. Allocation Shifts
k. Reclassifications
l. Adjustments
m. Kidney Acquisition Costs

Some pre-audit tests are positive indicators; therefore, field work should not be undertaken unless tests indicate otherwise. Examples of this would include FICA Tax and Unbundling (See Exhibit 5).

Some pre-audit tests are negative indicators; therefore, field work should be done unless tests indicate otherwise. An example of this type of testing would be the use of comparative analysis.

4202.3 Performance of Hospital Audits - General.—Audits will be conducted using due professional care. Intermediaries must continue to meet the requirements for standard field audit programs which clearly state the audit objectives under the prospective payment system and maintain consistency with the scope determined in pre-audit. Accordingly, Audit Performance Priority and Requirements are established as follows:

A. Audit Performance Priority.—Base year hospital audits are performed for three purposes: (1) determine the prospective payment system target rate, (2) determine the Tax Equity and Fiscal Responsibility Act (TEFRA) target amount, and (3) settlement of the base period cost report. Priority must be given to audit issues that will effect prospective payment target rates.

1. Audits should be completed as soon as possible.

2. The timely determination of prospective payment target amounts may necessitate deferring some work until after the target rates are set. Base period operating costs for prospective payment purposes must be determined on a timely basis using the best data available. However, the resolution of issues not impacting target rate computations (e.g., whether a lease/purchase situation exists) may be deferred until after the target rate is set if such deferral contributes to the intermediaries overall timeliness objective in setting target rates.

Under the best circumstances, the base year audit will be timed to allow for a review of the Medicare cost report as well as the adjustments claimed on Form HCFA-1008 and will accomplish all three of the purposes listed in §4202.3A. In some cases, an intermediary may have completed a base year cost report audit prior to the issuance of these instructions and may decide that prospective payment system considerations may not require any further audit work. In those cases, the intermediary must still insure that the procedures enumerated in §4202.3B, 1 through 4, are still reviewed in sufficient detail. In some audits, an intermediary may not accomplish all three of the purposes of the base year audit. The basis for intermediary decisions as to the scope of audit appropriate under the circumstances must be documented and reasonable.

B. Audit Performance Requirements.—All audits should be performed in such a manner as to produce the best possible timely determination of allowable, allocable, and reasonable Medicare operating cost for prospective payment system purposes.

The depth of review required to properly perform an audit step is determined using professional judgement of the circumstances encountered.

For the purpose of target amount determinations, some audit procedures will be required in every audit because pre-audit activity may not indicate an exception. The following procedures are required:

1. Review the accuracy and propriety of adjusting entries. This review will include the pre-working trial balance and post working trial balance entries as well as Medicare cost report adjustments and reclassifications.

2. Review prepaid expenses to insure they have been properly recorded.

3. Review major purchases for the last 3 months prior to the end of the base year to insure they have been properly recorded.

4. Review the Medicare discharges to determine their accuracy for rate setting purposes.

4202.4 Target Rate Computation and Notification to Provider.—Upon completion of the field review, the intermediary will perform the following procedures necessary to compute the final target rate:

A. Accumulate all cost and discharge data necessary to calculate the target rate (include home office cost).

B. Calculate the rate from data accumulated and when necessary from the best data available. For appeal type issues, use the last known HCFA position in resolution.

C. Notify hospitals by certified mail of the rate no later than those time frames prescribed in the schedule presented in the background section of the chapter (˹4200).

D. Review the initial rate calculation giving consideration to any adjustments requested and supported by the provider resulting from its review of the initial notification.

E. Where the rate changes, issue revised determination of the target rate to the provider by certified mail return receipt requested no later than the day proceeding the first day the prospective payment system goes into effect to that provider.

4204. INSTRUCTIONS TO HOME OFFICE INTERMEDIARIES

4204.1 General.—Chain home office costs can significantly impact a provider's target rate computation and can materially affect a provider's reimbursement for pass-through items such as capital related costs. Accordingly, chain home office intermediaries are subject to the protocols described in this section for provider base period audits, as well as the protocols contained in this section which specifically pertain to home offices.

4204.2 Preparing for Chain Home Office Audits.—

A. Work Planning and Audit Priority.—All chain home office cost statements relative to provider base periods must be audited. There will be no exceptions to this rule even where the base period audit for a particular provider has been waived. Chain home office audits are to receive the highest degree of priority as intermediaries prepare audit inventories and audit workplans. Further, it is absolutely essential that intermediaries recognize their chain home office audit responsibility to properly evaluate their management resource needs.

B. Requesting Supplementary Chain Office Data.—To aid the pre-audit planning of a chain home office audit, the intermediary may find it beneficial to obtain supplementary data specific to prospective reimbursement from the chain home offices. Form HCFA-1008 has been designed to obtain this data from the providers and will also be used by chain home offices where appropriate. The primary concerns of the Form HCFA-1008 data which may apply to chain home offices are FICA tax and directly assigned capital costs. However, depending on a particular chain's accounting policies, it is possible for other items on the Form HCFA-1008 to be applicable. Because of the variety of fiscal year ending dates of chain member providers, home office intermediaries may need to initiate a request for the submission of Form HCFA-1008 from home offices.

C. Pre-audit Activity.—In the absence of standardized desk review and other audit scoping procedures, intermediaries will perform, as usual, those procedures which they have adopted for this purpose. It is the intent of this manual section to assure that indepth audits are performed for the purpose of calculating base period rates. An intermediary's pre-audit procedures should include, but are not limited to the following:

1. Determine from local intermediary notices, the cost statement fiscal periods which must be reviewed.

2. Ensure timely filing of all home office cost statements and HCFA-Form 1008 supplementary data.

3. Determine the extent of supplementary information (financial statements, working trial balances, supporting schedules, etc.) which are needed to assist in scoping the audit and obtain this data from the appropriate home office.

4. Review notes to subsequent year desk review/audit.

5. Review notes to financial statements.

6. Review permanent files for items which would affect home office costs and capital.

7. Review prior year desk and/or field audit adjustments.

8. Review prior year summary of exceptions and related workpapers.

9. Perform a variance analysis. (Note: additions/deletions to chain components which would affect variance analysis conclusions.)

D. Special Audit Issues.—In addition to exceptions noted in the pre-audit process, the intermediary should consider the following issues:

1. Total Effective Compensation

    a. Owners compensation
    b. Non-owner compensation
    c. Fringe benefits
    d. Employee stock option/purchase plans
    e. Bonuses
    f. Severance pay
    g. Nonpaid worker's - imputed costs
    h. Unusual overtime

2. Appealable Issues

    a. Acquisition costs
    b. Income tax
    c. Stock maintenance costs
    d. Other

3. Reasonable Cost Issues

    a. Travel/entertainment
    b. Automobile/airplane
    c. Legal and accounting
    d. Other consulting
    e. Related organization transactions and exceptions
    f. Corporate reorganization

4. Statistical Method Issues

    a. Functional allocation method
    b. Double allocation method — health care/nonhealth split
    c. Health care component split

E. Audit.—Chain home office audits must include the following audit features:

1. Capital related costs must be computed and identified to permit exclusion from the provider target rate.

2. Other target year adjustments (FICA, medical/paramedical education costs, etc.) which are based on the Form HCFA-1008 must be determined.

136

4204.3 Audit Resolution and Transmittal to the Local Intermediaries.—Based on the significance of chain home office costs and capital related costs, it is presumed that chain home office audits for target rate computation will also facilitate final settlement of provider cost reports. However, there may be instances where an audit would not provide for the provider's final settlement (nonconcurrent reporting periods, audit scope limited to target rate adjustment areas, there is no full period cost statement, etc.). Accordingly, chain home office intermediaries will transmit audit results to the local intermediaries as follows:

A. Final Home Office Cost Statement.—Where the cost statement has been subjected to a routine finalization process (i.e., the review has been completed), the final revised cost statement may be issued. This cost statement will be used for both the target rate determination and the final Medicare reimbursement settlement (issuance of the NPR).

B. Target Rate Determination Only.—Where the cost statement has been processed only to arrive at a best estimate for target rate purposes (i.e., the cost statement review is not finalized for Medicare reimbursement settlement purposes), a target rate determination only notification should be issued to the local intermediary. This notice should identify:

1. Directly assignable costs (reclassifications to the providers) identifying both capital costs and other costs,

2. Interest income/expense, identifying both capital-related and general,

3. Home office costs (functional plus pooled to be included in A&G),

4. Home office capital-related costs, and

5. FICA tax and other Form HCFA-1008 supplementary data.

In both cases, transmittal of the final information must be made by the home office intermediary to ensure local intermediary receipt no later than 15 days before the deadline for local intermediary issuance of the provider target rate amounts.

(NOTE: For a nonconcurrent reporting period which is not supported by a filed cost statement, the transmittal should provide a formula for estimating/extrapolating the concurrent period amounts. The formula devised by the chain home office intermediary must be reasonable and equitable and should not be at a rate which would exceed the concurrent period.)

A. Development of the Amount of Home Office Cost To Be Allocated to Individual Hospitals for Nonconcurrent Reporting Periods.—The following steps are recommended for the development of the formula for estimating the current period amounts:

1. Audit the base year home office cost statement to determine the proper amount of home office cost to be allocated to each hospital member of the chain.

2. Determine (from the home office records) the amount charged to each individual hospital of the chain during the period covered by the chain home office cost statement under review.

3. Divide the amount of audited cost for each hospital (as developed in §4204.4.A.1,) by the amount charged to each individual facility during the period covered by the chain home office cost statement under review (as developed in §4204.4.A.2) to determine the percentage relationship of audited home office cost to estimated home office charges for each hospital member of the chain.

4. Multiply the percentage developed in §4204.4.A.3 times the amount of home office charges shown on the provider's Form HCFA-2552-81, Worksheet A-8-1 to determine the amount of home office cost to be allowed for the individual hospital for the nonconcurrent reporting period.

5. For those providers that fail to disclose home office charges on Form HCFA-2552-81, Worksheet A-8-1, develop (from the home office records) the amount charged to that provider during the period covered by the provider's cost report.

6. Multiply the percentage developed in §4204.4.A.3 times the amount of home office charges as developed in §4204.4.A.5 to determine the home office cost to be allowed the provider for the nonconcurrent reporting period.

B. Development of the Apportionment Between Cost Pass-Throughs (Capital Related Cost, Medical Education Cost) and the Amount to be Included in the Development of the Target Rate Determinations.—

1. Develop from the audit of the base year home office cost statement the amount of capital related costs and medical education costs which qualify as cost pass-throughs to be allocated to each member of the chain under the Prospective Payment System for the period covered by the chain home office cost statement under review.

2. Divide the pass-through amount for each chain member (as developed in §4204.3.B.1) by the audited amount of home office cost for each chain member (as developed in §4204.4.A.1) to determine the percentage relationship between cost pass-through amount to total audited cost allocated to each hospital member of the chain.

3. Multiply the percentage developed in §4204.4.B.2 times the amount of home office cost developed in §4204.4.A.4 to determine the amount of estimated cost pass-throughs for each chain home office provider for the nonconcurrent reporting period.

4. Subtract the amount developed in §4204.4.B.3 from the amount of cost developed in §4204.4.A.4 to determine the amount of home office operating cost for each provider to be included in the determination of the target rate amount.

4299. EXHIBITS

Exhibit 1 - Capital Related Costs
Exhibit 2 - Medical Education
Exhibit 3 - FICA Tax
Exhibit 4 - Provider-Based Physicians
Exhibit 5 - Non-Physician Services Billed Under Part B (Unbundling)
Exhibit 6 - Medicare Discharge
Exhibit 7 - Prepaid Expenses
Exhibit 8 - Inventories
Exhibit 9 - Accruals
Exhibit 10 - Allocation Shifts
Exhibit 11 - Reclassifications
Exhibit 12 - Adjustments
Exhibit 13 - Kidney Acquisition Costs
Exhibit 14 - Changes in Accounting Practices
Exhibit 15 - Nonrecurring Cost in the Base Period

Exhibit 1

Capital Related Costs

Issue: To insure that all capital related costs are excluded from the base year cost report for target rate computation.

Concern: That the target rate will be artificially inflated by the failure to exclude capital related costs from the rate setting process.

Pre-Audit Tests

1. Review the data submitted by the provider with Form HCFA-1008 noting any variance with the total amount as claimed on HCFA Form 2552-81, Worksheet D-1, Column O, line 25AA.
2. Review the comparative analysis of operating costs noting significant changes in the depreciation as well as other cost centers since depreciation may have been directly assigned.
3. Review W/S A-8 and W/S A-8-1 to determine whether related organization cost is included in the cost report. If so, determine whether capital related costs were identified and included in the depreciation cost centers.
4. Review W/S A-1 and W/S A-6 to determine whether capital related interest, insurance and taxes were reclassified from A&G to Depreciation.
5. Analyze the Working Trial Balance to identify the directly assigned capital related cost amounts.
6. Scan the financial statements for disclosures on changes in capitalization policies and major changes in fixed asset balances.
7. Review the capitalization policies and lease agreements which are maintained in the intermediary's files.

Audit Emphasis

1. Obtain explanations from the provider for all exceptions noted in the pre-audit.
2. Verify the explanations through tests of source documents such as purchase orders and invoices.

Exhibit 2

Medical Education Costs

Issue: Costs of approved paraprofessional Medical Education and programs are often expensed directly in department cost centers and cannot be separately identified based on the hospital's cost report.

Concern: Provider may not submit all training costs to the intermediary (on the Form HCFA-1008) for elimination from the cost report for rate setting purposes. Instead they may submit only enough to establish that these programs are in existence and thereby establishing the medical education pass through to artifically inflate the target rate.

Pre-Audit Tests

A. Where Medical Education Costs Are Directly Assigned To Cost Centers

1. Review the provider's Working Trial Balance (WTB) to determine if Medical Education Costs have been directly charged to cost centers.

2. Compare the amounts shown on the Form HCFA-1008 with the amounts identified on the provider's WTB.

3. Compare amounts claimed on the base year WTB with prior year to determine if there has been any significant decrease in the amounts shown for Medical Education.

4. Where material variances are found in 2 & 3 above, refer to audit.

B. Where A Separate Cost Center Is Established For Medical Education.—Review comparative cost analysis.

1. Direct Costs

   a. Review Worksheet A, Columns 1 and 2
   b. Review Worksheet A-6 and A-8
   c. Where material variances are found, scope for further audit work

2. Indirect Costs

   a. Review Worksheet B and B-1
   b. Where material variances are found in amount of allocation or in cost centers allocated, scope for further audit work

Audit Tests

A. Where Medical Education Costs Are Directly Assigned To Cost Centers

1. Obtain schedule from provider (if not submitted with Form HCFA-1008) showing:

    a. Type of program
    b. Net cost of each program
    c. Cost center in which expenses are recorded

2. Review and analyze schedule as necessary

3. If necessary documentation is not provided, note in file for consistency in treatment for future periods and prepare adjustment.

B. Where A Separate Cost Center Is Established For Medical Education

1. Direct Costs

    a. Test exceptions noted on the comparative cost analysis

    b. Substantiate explanation through analysis and vouching

    c. Examine license or other relevant documents for proper approval of educational programs

    d. Update permanent file with available information

2. Indirect Cost Exceptions

    a. Trace statistics to source data

    b. Review method used in gathering statistics and determine reasonableness of basis used (i.e., does basis reflect actual operations?)

Exhibit 3

Federal Insurance Compensation Act (FICA)

Issue: Certain hospitals have not been participating in FICA and, therefore, such costs are not reflected in their base period cost reports. Since all nongovernmental hospitals will be required to pay FICA tax beginning January 1, 1984, an adjustment in recognition of the higher payroll cost must be made.

Concern: The reasonableness of the amount of FICA tax claimed by the provider on Form HCFA-1008, line 7.

Pre-Audit Tests

Compare amounts claimed on the Form HCFA-1008 with an estimated FICA amount determined by applying the proper FICA tax rate (HCFA Pub. 15-1, §2802) to total salaries shown on Schedule A of the cost report. If the provider's estimate of the FICA taxes that would have been paid in the base period if the provider had been subject to FICA in the base period appears to be reasonable, no further audit work is necessary. If the amount of FICA tax estimated by the provider appears to be unreasonable, field audit may be necessary.

The following are the applicable FICA rates:

FICA Maximum Taxable Amounts	FICA Tax Rate
1980 - $25,900	6.13 percent
1981 - $29,700	6.65 percent
1982 - $32,400	6.7 percent
1983 - $35,700	6.7 percent

Audit Tests

Perform tests as necessary of the actual provider wage records to properly support or adjust the amount of FICA tax claimed by the provider. Apply standard salary audit procedures and the FICA tax rates.

Exhibit 4

Provider-Based Physicians

Issue: To adjust the base period costs for the estimated provider-based physician (PBP) costs which would have been allowable if the regulations published in the Federal Register 48 FR 8902 to 8951 had been in effect during the base period.

Concern: The base period cost report contains treatment of the provider component of provider-based physician remuneration under rules that are different than those that apply on or after May 31, 1983. However, section 405.550(e), affecting agreements under which physicians (or other entities) assume some or all of the operating costs of a provider department, contains provisions indicating that it will not be applied until June 30, 1983, for lease agreements established on or after July 1, 1966 and until March 2, 1985 for agreements established before that date. Therefore, adjustments that are not applicable to the settlement of the base period cost report must be made in setting the target rate.

Pre-Audit Tests

1. Review documentation (schedules) submitted by the provider in response to the information requested by the Form HCFA-1008.
2. Review time rationale available (from permanent PBP files) to determine provider component.
3. Evaluate remuneration for reasonableness. (Note: Do not use Reasonable Compensation Equivalents (RCEs) as shown in the Federal Register, pages 48 FR 8902 to 8951 on March 2, 1983.)
4. Prepare necessary adjustments and conclusions.

Audit Tests

1. None necessary at this time.

Exhibit 5

Non-Physician Services Billed Under Part B (Unbundling)

Issue: Prior to October 1, 1983, payment for non-physician services furnished by an outside source to hospital inpatients could have been made either to the hospital (under Part A), to the beneficiary, or if assignment was taken, the entity that furnished the services (under Part B). Effective October 1, 1983, all hospitals must furnish either directly or under arrangements all items and non-physician services received by Medicare inpatients. A few hospitals may continue to have outside sources bill directly for their services during the 3 year transition period (602(k) of P.L. 98-21). Exceptions for continued separate direct billing under Part B by suppliers or other providers for services to hospital inpatients are expected to be limited to circumstances where virtually all ancillary services are contracted out.

Concern: Improper presentation of unbundling costs which would artifically inflate the base period target rate.

Pre-Audit Work

1. The fiscal intermediary will give the Part B carriers a listing (mag type) of hospital discharges for the month of September 1982 by June 1, 1983. The listing will be in a standard format as specified in a separate instruction.

2. The Part B carrier will furnish the fiscal intermediary a listing (mag type) for HI claim number and dates of service between dates of admission and dates of discharge. The listing will be in a standard format to be specified in a separate instruction.

(NOTE: The carrier will also give the intermediary a description of the procedure codes employed.)

3. The fiscal intermediary will sort the magnetic tape file received from the carriers into Provider Number Order.

4. The fiscal intermediary will divide the number of discharges (those Medicare beneficiaries discharged in September 1982) into the aggregate supplier reasonable charge (the amount of reasonable charges as determined by the listing received from the Part B carrier) to determine the average reasonable charge (for the unbundling services) per Medicare discharge occurring in September 1982.

5. Multiply the average reasonable charge per Medicare discharge (as computed in 4 above) by the total Medicare discharges reported by the provider to arrive at the aggregate unbundling cost to be included as an adjustment to the Medicare cost report to be included in the target amount computation.

6. Compare the results from number 5 above to the amount claimed by the provider on the Form HCFA-1008 to determine whether an adjustment to the amount claimed by

the provider is required. In determining the amount of adjustment to be applied, apply the following materiality criteria.

a. If the amount of the adjustment is $5,000 or less in each of items b and c, below, based on the hospital's estimate, use the hospital's estimate to adjust the base period costs without further action.

b. If the base period adjustment would exceed $5,000 based on the hospital's estimate and the estimated costs do not involve any physician component:

   (1) Use the hospital's estimate to adjust the base period costs if that estimate is not more than 110 percent of the annualized amount based on data received from the carrier(s).

   (2) If the hospital's estimate exceeds 110 percent of the annualized carrier data request the hospital is to furnish documentation to support their estimate:

      (a) if the hospital cannot substantiate its estimate (or any amount in excess of the carrier's data). Use the amount computed in 5 above as the unbundling adjustment to base year costs.

      (b) If the hospital is able to substitute its estimate, refer the documentation received from the hospital to audit.

c. If the base period adjustment would exceed $5,000 based on the hospital's estimate and the estimated costs involve physician component amounts:

   (1) Use the hospital's estimate to adjust the base period costs if that estimate is 90 percent or less of the annualized amount based on data received from the carrier(s).

   (2) In all other circumstances, the difference is considered material and the intermediary should refer to audit to reconcile the difficulties.

Audit Tests

1. Test the documentation received from the hospital for reasonableness.

2. Reconcile the differences with the hospital. Differences may occur from:

   a. Services billed to carriers in other States.

   b. Services billed by other providers as outpatient services.

Exhibit 6

Medicare Discharges

Issue: Target amount calculations for prospective reimbursement are based on cost per discharge.

Concern: The accuracy of the Medicare discharge data used for the target rate calculation.

Pre-Audit Tests

1. Compare Medicare discharges shown on the provider cost report with Medicare discharge data maintained in the intermediary bill processing system.
2. Where there is a significant difference attributable to factors other than to the late submission of discharge bills or other known problems, refer to audit.

Audit Tests

1. Review the provider's system for accumulating discharge data.
2. Test the clerical accuracy of the provider's Medicare discharge summary and trace the totals to the cost report.
3. Test the accuracy of the provider's Medicare discharge summary by tracing selected entries to the patient medical files.

Exhibit 7

Prepaid Expenses

Issue: To insure that prepaid expenses have been properly recorded on the balance sheet. To verify that supplies have been properly inventoried.

Concern: Material prepaid amounts which were expensed but should have been inventoried.

Pre-Audit Steps

1. Review financial statements prepared by the provider's Certified Public Accountant to determine if there has been any substantial decrease in prepaid expenses.
2. Review the opinion issued by the provider's accountant to determine if there are any qualifications relating to prepaid expenses.
3. If there has been a substantial increase in purchases (relating to inventory) without a corresponding increase in inventory, refer to audit.

Audit Steps

1. Review of the last three months of the cash disbursement or purchase journals for major purchases.
2. Verify above as to whether the items have been properly inventoried.

Exhibit 8

Inventory

Issue: To insure that inventory has been properly recorded on the balance sheet.

Concern: The existence of Inventory of Supplies and Pharmacy utilizing approved inventory methodology. In addition to insure that inventory valuation was not changed to artificially inflate expense.

Pre-Audit Steps

1. Review financial statements prepared by the provider's Certified Public Accountant to determine if there has been any substantial decrease in inventory.
2. Review the opinion issued by the provider's accountant to determine if there is any qualification relating to inventory.
3. Review the financial statements for notes denoting a change in inventory valuation.
4. Where there is a change in valuation determine if method is an approved method.
5. If a significant decrease in inventory valuation has occurred, refer to audit.

Audit Steps

1. Review of the last three months of the cash disbursement or purchase journals for major purchases.
2. Propose adjustments for inventory items which were expensed.

Exhibit 9

Accrued Expenses and Accounts Payable

Issue: Changes in a provider's accounting policy or improper accounting for purchases may unjustifiably increase the base period target rate (e.g., expensing material purchases which would normally be inventoried).

Concern: Accrued expenses and purchases were properly charged in the base period according to Generally Accepted Accounting Principles (GAAP).

Pre-Audit Tests

1. If available, review the audited financial statements (auditor's opinion and notes to financial statements) for information pertaining to accounting policy for inventories, purchases, and accruals.

2. Review expenses which were accrued in the base period for any unusual items.

3. Compare expenses which were accrued in the base period with expenses accrued in the prior period. Note variances and new accruals.

4. Review accounts payable for unusual items, and notable variance with payables shown in the prior period.

5. Perform a comparative analysis of "other costs" shown on schedule A of the base period cost report with amounts shown in the prior period cost report for the following cost centers:

    a. Central Services and Supply
    b. Pharmacy
    c. Medical Supplies Charged to Patients
    d. Drugs Charged to Patients
    e. Administrative and General
    f. Maintenance and Repairs
    g. Laundry and Linen Service
    h. Housekeeping

Audit Steps

1. Review adjusting journal entries and provider documentation which supports accrued expenses.

2. Perform additional audit procedures as necessary to insure a liability exists.

3. Insure that the accounting for unusual purchases noted in the pre-audit tests is in accordance with Generally Accepted Accounting Principles and, if appropriate, that purchases have been properly inventoried.

Exhibit 10

Allocation of Costs Between Inpatient Hospital Services, Outpatient Medicare Services and Sub Providers

Issue: Improper allocation of costs from Medicare Part B reimbursable services and sub-providers to inpatient Part A services would artificially inflate the base period target rate.

Concern: Improper provider reimbursement caused by an inflated base period target rate and cost reimbursed Part B services.

Pre-Audit Tests

1. Review in detail the comparative analysis of cost report worksheets B and B-1 and schedule C. Note variances in allocation statistics and amounts (expenses, charges, and revenue).
2. Review worksheets B-1 and C along with the reclassifications and adjustments made to worksheet A of the cost report for items which would affect the allocation of cost to inpatient care.
3. If financial statements and/or trial balance of expenses are available, review pertinent accounts and reclassifications which were made during the preparation of the cost report.
4. Review permanent reference files and correspondence files for approval of changes in allocation basis if applicable.

Audit Tests

Perform standard field audit procedures as necessary to support or adjust exceptions noted in the pre-audit.

Exhibit 11

Reclassification of Expenses

Issue: Improper reclassification of expenses and/or cost centers that would artificially inflate the base period target rate.

Concern: Accuracy and propriety of provider reclassifications (Cost Report Schedule A-6).

Pre-Audit Tests

1. Compare accounts (including amount) shown on the current trial balance of expenses with those of the prior year.

2. Review the reclassifications which occurred during cost report preparation by comparing the accounts shown on the trial balance of expenses with the accounts shown on Schedule A of the cost report. Compare the results of this analysis with the results of the same analysis performed for the prior periods cost report.

3. Compare the Cost Report Schedule A-6 reclassifications for the current period with those of the prior periods cost report.

Audit Tests

Applying Medicare Principles of Reimbursement, perform all standard field audit procedures to any exception or impropriety noted in the pre-audit tests.

153

Exhibit 12

Adjustments to Expenses

Issue: Improper adjustments of expenses which would artificially inflate the base period rate.

Concern: Accuracy and propriety of adjustments to expenses.

Pre-Audit Tests

1. Evaluate the propriety of the adjustments to expenses shown on Schedule A-8 of the cost report by comparing them with the prior periods cost report adjustments (account classifications and amounts).
2. Insure that all adjustments which should have been made were included on Schedule A-8 of the cost report by comparing Schedule A-8 with the account activities shown on the trial balance of expenses and revenue statements.
3. Miscellaneous revenue which is material in amount and which did not appear on Schedule A-8 should be noted for audit.

Audit Tests

1. Obtain valid support for any exceptions noted in the pre-audit by performing, as necessary, standard field audit procedures.
2. Review journal entries prepared by provider and provider's accountant to ascertain that all adjustments made to the initial trial balance (taken from the provider's general ledger) were proper and supportable.

Exhibit 13

Kidney Acquisition Cost

Issue: Accurate presentation of kidney acquisition costs reflected in the base period cost report.

Concern: Improper presentation of kidney acquisition costs which would artificially inflate the base period target rate.

Pre-Audit Tests

1. Compare amounts reflected in the cost report for kidney acquisition with the intermediary provider payment records.
2. Compute and compare the average revenue earned per kidney acquisition to the current period with that of the prior reporting period.
3. Compare amounts shown on worksheet D-6 of the cost report (parts A&B) with those of the prior reporting period.
4. Compare the direct costs attributable to kidney acquisition with that of the prior year.

Audit Tests

1. Review the provider's system for accumulating kidney acquisition cost and revenue data.
2. Review the clerical accuracy of the provider's kidney acquisition summary (inventory, log, etc.).
3. Verify the accuracy of the log by tracing selected entries to the provider's medical files.
4. Test revenue data by multiplying the provider's standard kidney acquisition charge times the number of kidneys shipped to other providers.
5. Verify the accuracy of salary expenses charged to kidney acquisition. Verify the personnel service cost which was charged to acquisition and the method of allocating these costs to their various functions (e.g., test time activity reports and actual employee function).

Exhibit 14

Changes in Accounting Practices

Issue: Changes in accounting practices and procedures which inflate base period costs.

Concern: That the target rate will be artificially inflated by the provider's changing accounting practices in the base period. The change in accounting practice would inflate the provider's cost experience above the cost that would have been reported under the previously applied accounting practices. (HCFA Pub. 15-1, § 2802.B9.)

Pre-Audit Tests

1. Compare current year cost with prior year cost to detect any significant changes in the trial balance and/or adjustments on Schedule A-8 of the cost report which may be an indicator of changes in policy.

2. Review notes to the financial statement for possible changes in accounting policy and practices.

Audit Tests

1. Review accounting policy manual and Board of Directors' Minutes for possible changes in accounting practices, incorporating any findings from the Pre-Audit review of the notes to the financial statement.

2. Review the outside CPA firm's internal control questionnaire for possible changes in accounting practices.

Exhibit 15

Nonrecurring Cost in the Base Period

Issue: Higher costs in the base period which inflate the target rate.

Concern: That the target rate will be artificially inflated by higher costs that were incurred for the purpose of increasing base year costs or that have the effect of distorting base year costs as an appropriate basis for computing the hospital-specific rate. (HCFA Pub. 15-1, §2802.B9.) Examples of such costs are:

- o One time bonuses paid to executives or employees in lieu of a payraise in the succeeding year.
- o Additional payments to the pension fund to either prepay the succeeding year's payment or to cover the preceeding year's payment which was defaulted by lack of capital.
- o Significant changes in inventory caused by one time write offs.

Pre-Audit Tests:

1. Comparison of current year cost with prior year's cost for detection of significant increases in base year cost.
2. Review where available the notes to the financial statement for indications of possible nonrecurring cost items.

Audit Tests:

1. Review Board of Directors' Minutes and where independent audit is performed, the CPA firms' internal control questionnaire for indication of nonrecurring cost items.
2. Evaluate through field audit those findings in the pre-audit tests which appeared to warrant adjustment of cost.

* U.S. GOVERNMENT PRINTING OFFICE: 1983-381-858:461

157